REQUEST FOR CONTINUAL REIMBURSEMENT

DEPENDENT CARE EXPENSE or PERSONALLY PAID HEALTH INSURANCE PREMIUM

Please check the appropriate category: ☐ Dependent Care Expense (DCAP) ☐ Personally Paid Premium Expense (PPP)

EMPLOYEE INFORMATION: (Must be completed in full)

Employer's Name ________________ Plan Year 2010

Participant's Name ________________ SS # ________________

Participant's Address ________________

Home Phone# ________________ Work Phone # ________________

DEPENDENT/CHILD CARE PROVIDER and/or HEALTH INSURANCE PROVIDER INFORMATION:

Dependents' Names 1________ 2________ 3________

Birth Dates 1________ 2________ 3________

Relationship to Participant ________________

Provider's Name ________________

Provider's Address ________________ City ________ State ____ Zip ________

Provider's Phone # ________________ Provider's Tax ID# or SS# (if DCAP)________________

Provider's Signature ________________ Date ________________

- If for Dependent Care (DCAP) Provider must sign this request
- If for Personally Paid Premium (PPP) please attach documentation (monthly or quarterly invoice)

MONTHLY DETAIL:

Dependent Care Expenses or Personally Paid Health Insurance Premiums to be claimed for Reimbursement

List Months in Plan Year	Monthly Expense	Explanation if Needed:
1. ________	$________	
2. ________	$________	
3. ________	$________	
4. ________	$________	
5. ________	$________	
6. ________	$________	
7. ________	$________	
8. ________	$________	
9. ________	$________	
10. ________	$________	
11. ________	$________	
12. ________	$________	

Total Annual Dependent Care or Personally Paid Health Insurance Premium $________________

Claims must be made for services incurred during the plan year. These requests pertain to expenses which you incur regularly under a binding agreement. No reimbursement may be paid under this continual reimbursement program for any month in which Dependent Care Services and/or Personally Paid Health Insurance Premiums expenses are not rendered or incurred. It is your responsibility to advise the Plan Administrator of the cessation or interruption of such services.

PARTICIPANT AGREEMENT

I have verified that the information listed above and the information attached is true and correct. I understand that if any changes regarding the continual payments or services occur, Flex-Advantage must be notified immediately. Failure to do so could result in additional taxes for which I would be responsible and liable.

Participant's Signature:________________________ Date________________