Dependent Care
Expense Documentation

Name ______________________ Last 4 digits of SS# __________

Address ______________________ Is this a new address? ☐ **YES** ☐ **NO**

City, State, ZIP ______________________

Phone ____________ ☐ cell ☐ home ☐ work Email ____________

Dependent Name ______________________ Dependent Age __________

Provider Name ______________________ Federal Tax ID __________

Provider Address ______________________

Payment Amount $ __________ Service Start Date __________

Number of Payments __________ Service End Date __________

Total Paid to Provider $ __________

Note: You can claim the total expenses you plan to pay this plan year with appropriate documentation.

Submit this form and documentation to:

Fax (904) 880-2830

Mail BenefitsWorkshop
P.O. Box 56828
Jacksonville, FL 32241

Questions? Contact us!

Email info@benefitsworkshop.com

Phone (888) 537-3539

Website benefitsworkshop.com/employeeinfo

IMPORTANT: Documentation Requirements
Forms must be signed by the participant. All forms must be accompanied by valid receipts or a provider's signature. To claim expenses not yet paid to the provider, either have the provider sign this form or provide a service contract.

By signing below, you certify that the payment amount and service dates are accurate and both the participant and provider will notify BenefitsWorkshop if circumstances alter the payment amounts and/or dates of service.

______________________ __________
Provider Signature Date

______________________ __________
Participant Signature Date