



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/oaklandpark

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