SECTION 125 FLEXIBLE BENEFIT PLAN

DEPENDENT CARE CLAIM FORM

Employee Name:	Member ID or Social Security Number:
Residence Address:	
City / State / Zip Code:	
E-Mail Address:	Daytime Phone Number:

Instructions: Please list the amount of reimbursement you are requesting under "Service Provider Information" below. For all expenses to be reimbursed attach copies of all receipts showing who rendered the service, date of service and the charge amount. If you are unable to obtain a valid receipt, please have the provider sign and date this form below.

The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary of your spouse. (If your spouse is either (a) a full time student or (b) is incapable of taking care of himself/herself, then he/she is deemed to have monthly earnings of $200, if you have one child or dependent, and $400 if two or more.) No payment may be made under the Plan if the service provider is your dependent for Federal income tax purposes. No payment may be made if the Service Provider is under the age of 19. No payment may be made if your child or stepchild is over the age of 18 unless the child qualifies as physically or mentally handicapped.

Please retain all original receipts
(should you be auditted by the IRS they can request records of up to seven years)

Name of Dependent:		
Period Covered:	From:	To:

SERVICE PROVIDER INFORMATION

Name:	
Taxpayer I.D.:	Daytime Phone Number:
Total Number of Receipts:	Total Amount Requested: $

Service Provider Signature (Required only when there are no receipts attached) Date

I certify that the above information is correct and hereby authorize release of payment through my reimbursement account(s). I further certify that these expenses have not been and will not be reimbursed under the Plan, or any other plan or program of any employer or other person. I understand that I am fully responsible for the accuracy and sufficiency of all information relating to this claim. I understand that no dependent care tax credit is permitted on my Federal income tax return for amounts reimbursed under this plan. The Plan Administrator does not accept responsibility for direct payment to any individual other than the employee.

Employee Signature Date

PLEASE RETURN FORM TO:

Caprock Health Plans
Post Office Box 780548 . San Antonio, TX 78278
Phone (210) 348-7300 . (800) 840-3977. Fax (210) 348-7112
Email: reimbursement@caprockhp.com

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