

PLEASE COMPLETE AND SUBMIT TO:
PRIMARY PHYSICIANCARE
ATTN: FLEXIBLE BENEFITS
DEPARTMENT
P.O. Box 11088
CHARLOTTE, NC 28220
PHONE: 704-523-2758
FAX 704-496-2367



Request for Dependent Care Expense Reimbursement

Company Name: _____

Employee Name: _____ SS# _____ / _____ / _____

Dependent Name(s):

Date of Birth: _____ TIN# _____

Day Care Provider: _____ SS# _____ / _____ / _____

Address: _____

Date of Services: _____ Through _____

Charge for Service: Per Hour: _____ Per Day: _____ Per Week: _____

Total Charges: _____

Employee Certification

I request payment from the reimbursement account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I further certify that I have met all the requirements for reimbursement of dependent care expenses. I understand that reimbursed expenses cannot be claimed as a deduction on my personal income tax return.

Daycare Provider Signature

Date

Employee Signature

Date

**READ CAREFULLY
CLAIM FILING INSTRUCTIONS**

FILING A CLAIM UNDER THE DEPENDENT CARE ACCOUNT

When submitting receipts for Day Care simply:

- Attach your receipts to a completed reimbursement claim form OR
- Have dependent care provider sign the claim form.
- Submit claim to Primary PhysicianCare.

Revision 03/15/2007