



CONTRACT FOR SERVICES Dependent Care Reimbursement Account

Employer's Name: _____

Participant Name: _____
Last First Middle

Social Security Number: _____ - _____ - _____

Address: _____
Street

City State Zip Code Phone Number

This is to certify that I have entered into an agreement with the provider listed below to receive
Dependent Care Services.

Full Name of Dependent: _____

Dates of Service: From: _____ To: _____

Annual Cost of Service: \$ _____ Weekly Cost of Service: \$ _____

Name of Dependent Care Provider: _____
Last First

Provider's Address: _____
Street

City State Zip Code Phone Number

Provider's Social Security or Tax ID Number: _____

I understand that I must keep all canceled checks and receipts for services rendered and that the plan administrator, Self Funding Administrators, may periodically request copies to verify expenses. I further understand that the above expenses are ones that I must pay for out-of-pocket, because they are not covered, have not been reimburse and are not reimbursable under any other Dependent Care coverage. I agree to submit any such information requested as proof of payment. I acknowledge that it is my responsibility to notify the plan administrator, Self Funding Administrators of any change to this Contract for Services. Furthermore, I understand that it is my responsibility to file a Form 2441 when I file my tax return.

Participant's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____