Dependent Care Account Reimbursement Request Form

Personal Information
Employer's Name
Participant's Name
Date:
Social Security Number

I hereby request reimbursement for the following expenses:

Expenses				
Date of Service	Dependent Name, Birth Date and Relationship	Provider Name and Address	Provider EIN (Tax ID or Social Security #)	Requested Amount

Total Amount for Dependent Care Reimbursement: $_____

Day Care Provider Information:

My signature certifies that I HAVE/WILL HAVE provided services for the dependent(s) noted above, during the dates specified, and for the amount requested.

Name/Organization: _____

Provider Signature:_____ Tax ID: _____

Please attach a copy of all supporting documentation. Undocumented claims will not be processed. The Plan Administrator may request that you provide additional documentation before any claim is paid. I understand I am only eligible to be reimbursed the amount I have contributed to the plan year to date. I certify that the information provided above is true and complete and that the expenses: (i) were incurred while I was a participant in the Plan, (ii) are deductible under Code section 129, (iii) were not used to claim a tax benefit, and (iv) are not covered, paid or reimbursed from any other source. I certify that if there is a change in the fees charged by my provider I will notify Alliance Insurance Group within 30 days.

Employee Signature:_____ Date: _____

Alliance Insurance Group
A Patriot Growth Company

Alliance Insurance Group
PO Box 240518
Montgomery, AL 36124
Ph: 866-396-3967 Fax: 334-396-7767
Email: fsa@allianceinsgroup.com