DEPENDENT CARE CLAIM FORM

122 Parish Drive
Wayne, NJ 07470

Employer Name:______________________________________

Employee Name:____________________________ ________________ SS#: _X_X_X_-_X_X_-__________
Last First Last 4 Digits Only

New Address:____

Email Address: ____

Date of Service	Service Provided	Dependent Name	Reimbursement Amount
		Total Reimbursable Expense	

Instructions:

1. Complete the top portion of the form.
2. List the eligible expenses:
   - Date of Service: The date (or date range) the service was provided. Not the date it was billed.
   - Service Provided: Provide a brief description of the service received.
   - Dependent Name: Refer to you FSA Handbook for information who you can claim as a dependent.
   - Reimbursement Amount: Enter the amount requested for reimbursement.
3. Sign and date your form.
4. Attach the required documentation:
   send copies of records supporting each listed item of expense or have your Day Care Provider sign the statement below.
5. Send completed form and attached documentation to gente.
   For Prompt Service Fax to: 973-694-2913 or email: claims@gente.solutions

Dependent Care Provider Statement:
I provided the Day Care services as stated above. Tax ID#__________________

______________________________________ ______________________________
Day Care Provider Signature Date

I certify that the expenses listed above have been incurred by me and/or my dependent(s) and qualify for reimbursement, and that these expenses will not be claimed as a deduction on my personal income tax return.

______________________________________ ______________________________
Your Signature Date