Dependent Care Spending Account
Continual Reimbursement Form

THE ADVANTAGE GROUP

Participant Information

Employer Name:		Plan Year:
Participant Name:		SSN:
Address:		Birth Date:
City, State, Zip:	Phone:	Email:

Dependent / Child Care Provider Information (provider's signature required)

Dependents' Name(s):	1)	2)	3)
Birth Date:	1)	2)	3)
Relation to Participant:	1)	2)	3)
Provider's Name:		Provider's Tax ID or SSN:	
Provider's Address:		Provider's Phone:	

Provider Signature: _____ Date: _____

Monthly Dependent Care Expenses

List Months in Plan Year	Monthly Expense	Explanation (if applicable)
Total Dependent Care Premium:		

Claims must be made for services incurred during the plan year. Requests include regularly incurred expenses under a binding agreement. No reimbursement may be approved thru a continual reimbursement program for any month in which Dependent Care Services are not rendered. It is your responsibility to advise the Plan Administrator of the cessation or interruption of such services. I have verified that the information listed above and the information attached is true and correct. I understand that if any changes regarding the continual payments or services occur, The Advantage Group must be notified immediately. Failure to do so could result in additional taxes for which I would be responsible and liable.

Participant Signature: _____ Date: _____