DEPENDENT CARE ACCOUNT
Reimbursement Request Form

Employer Name:	
Participant Name:	
Date:	
Social Security Number:	

I hereby request reimbursement for the following expenses:

Dates of service	Dependent Name, Birth Date and Relationship	Provider Name and Address	Provider EIN (Tax ID or Social Security Number)	$ 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

Submit Claims to:
Alliance Insurance Group, LLC
PO Box 240518
Montgomery, AL 36124
Phone: 334-396-3960 Fax: 334-396-7767
Email: fsa@allianceinsgroup.com
www.allianceinsgroup.com

Alliance Insurance Group
Employee Benefit Consultants