



This form is used when submitting a claim towards your Dependent Care Expense Account and you do not have, or cannot obtain, a receipt or statement as documentation of the expense. Submit this form, along with a completed claim form, to Benefit Resource, LLC.

| Employee Name | Date (MM/DD/YYYY) |
|---|------------------------------------|
| | |
| | |
| Dependent care services were provided for (name of dependent(s)): | |
| by (name of person/company providing the care): | |
| for services provided on the dates / / | through / / |
| Cost of these services: \$ | |
| | |
| Name of Person Providing Care | Signature of Person Providing Care |