Statement of Expense

DEPENDENT CARE

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

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

© 2024 Benefit Resource, LLC. | All rights reserved | Updated 8/30/2024 | Benefit Resource and BRI are tradenames of Benefit Resource, LLC
Benefit Resource, LLC is an affiliate of Inspira Financial Health, Inc. and Inspira Financial Trust, LLC. Benefit Resource, LLC does not provide legal, tax or financial advice. Please contact a professional for advice on eligibility, tax treatment and other restrictions. Inspira and Inspira Financial are trademarks of Inspira Financial Trust, LLC.