L.R. WEBBER ASSOCIATES INC
EMPLOYEE BENEFIT ADVISORS

L.R. Webber Associates
DEP. CARE CLAIM FORM

Employer Name: _____

Social Security No.:_____

Employee's Name:_____
Last First Middle

The undersigned participant in the plan requests reimbursement in the amounts shown below: (If additional space is needed, please use the attached sheet.)

Childcare Provider Name:_____

Address: _____

City, State, Zip:_____

Federal Tax ID Number or SSN: _____

Parent Name:_____ Child(ren) Name(s):_____

Daycare services for the child named above were incurred from:

_____ (MM/DD) to _____ (MM/DD) _____ (YEAR) COST: $_____

_____ (MM/DD) to _____ (MM/DD) _____ (YEAR) COST: $_____

_____ (MM/DD) to _____ (MM/DD) _____ (YEAR) COST: $_____

_____ (MM/DD) to _____ (MM/DD) _____ (YEAR) COST: $_____

_____ (MM/DD) to _____ (MM/DD) _____ (YEAR) COST: $_____

READ CAREFULLY

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the employers Dependent Care Reimbursement Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ Date_____
Provider's Signature

_____ Date_____
Employee's signature
Phone Number: _____

Submit Claim To:
Mail: L.R. Webber PO Box 593 Hollidaysburg, PA 16648 **Fax**: 814-317-1610 **Email**: Claims@lrwebber.com