



**ANNUALIZED DEPENDENT CARE REIMBURSEMENT FORM
REIMBURSEMENT REQUEST FORM**

Phone: 800.311.3842 ext 5

Fax: 866.514.8287

EMPLOYEE INFORMATION

Name	Social Security Number (last 4 digits)	Name of Employer
Member ID	Phone Number	Email Address

To help eliminate the need for multiple reimbursement requests throughout the year, we are offering annualized dependent care reimbursement. By completing this form you will automatically be reimbursed from your dependent care account as funds become available throughout the year. Please note that it is your responsibility to immediately report any changes you may have regarding the information below and a new form is required at the start of every new plan year

Dates of Service	Name of Dependent Care Provider	Caregiver's Address	Caregiver's SSN or ID#	Amount DUE in Dependent (DAYCARE) Expenses per week:

DEPENDENT CARE SPENDING ACCOUNT

Dependent #1 Full Name and Date of Birth	
Dependent #2 Full Name and Date of Birth	
Dependent #3 Full Name and Date of Birth	
Dependent #4 Full Name and Date of Birth	

DAYCARE PROVIDER or CARE FACILITY CERTIFICATION	DAYCARE PROVIDER or CARE FACILITY CERTIFICATION
I certify that I provided dependent care services as detailed above: Print Name: _____ Original Signature: _____ Date: _____	I certify that I provided dependent care services as detailed above: Print Name: _____ Original Signature: _____ Date: _____

CERTIFICATION

I certify that the following is true:

1. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
2. The expenses listed above were incurred by my eligible dependents and qualify for reimbursement

Employee Signature	Date
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Submit claim(s) electronically at myEVHC.com or through our convenient mobile app at **Benefit Spending Accounts** Or return this form to:

Attn: Evolution Healthcare
P. O. Box 25946
Overland Park, KS 66225
Phone: 877-267-3359
Fax: 866-514-8287
Email
address: FlexHB@luminarehealth.com

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