DEPENDENT CARE EXPENSE FORM

EMPLOYER **New Address Check Box:** ☐

NAME **SOC. SEC.#**

MAILING ADDRESS **Your Home Number:**

To have your claim processed immediately for a $5.00 fee. Please initial box: ☐

To have your check picked up by someone other than yourself. Please print name of person picking up check and initial box: ☐ _____

DEPENDENT CARE EXPENSE MUST BE INCURRED DURING THE CURRENT PLAN YEAR. DEPENDENT CARE CLAIMS FOR FUTURE SERVICES WILL NOT BE PAID UNTIL THE SERVICE ARE RENDERED. MAY FAX CLAIMS, BUT NEED TO MAIL IN ORIGINALS.

MAIL TO: DCB CLAIMS
ZESCH & PICKETT ADMINISTRATORS, INC.
P.O. BOX 431
SAN ANGELO, TX 76902
(325) 653-1448 OR (800) 259-7302
FAX: (325) 655-7245 MUST SEND HARD COPY.

DEPENDENT CARE EXPENSE CLAIMS

NAME OF DEPENDENT (S)	PERIOD FROM	COVERED TO	NAME AND IDENTIFICATION # OF PROVIDER OF SERVICES	AMOUNT INCURRED
				$
				$
				$
				$
			DEPENDENT CARE EXPENSE CLAIM TOTAL	$

PLEASE ATTACH A RECEIPT OR ITEMIZED BILL LISTING THE ABOVE INFORMATION. CANCELLED CHECKS OR BILLS SHOWING A PATENT OR PREVIOUS BALANCE ONLY ARE NOT ACCEPTABLE. LATE FEES ARE NOT REIMBURSABLE.

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earrings of $200.00 if there is one (1) child or dependent, and $400.00 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child, stepchild and is under age 19.

_____ _____
Employee's Signature DATE

FOR OFFICE USE ONLY

CLAIMED AMOUNT: **CHECK #**

PAID BY

CHECK AMOUNT: **DATE POST**