Strategic Business Services
Dependent Care Reimbursement Request Form

Remit To:
SBS Claim Processing
7422 Carmel Executive Park Drive
Suite 212
Charlotte, NC 28226
FAX: 888-923-9977
Email: claimprocessing@125admin.com

Employee Information

Employer Name:		Daytime Phone:	
Employee Name:		SSN #:	
Employee Address:		Apt/Suite:	

City:		State:		Zip:		E-Mail:	

PLEASE NOTE: Claims that are not listed on this form cannot be processed. You must complete each field below for each claim you are seeking reimbursement for.

Dependent Daycare Expenses (Attach supporting documentation if provider does not sign form)

Supporting Documentation for dependent care expenses is required only if provider does not sign this form. Otherwise, documentation must include the following:

- ☐ Provider's Name
- ☐ Address
- ☐ TaxID
- ☐ Amount
- ☐ Dependent's Name

Dates of Service		Amount	Dependent Name and Birth Date	Provider Name	Provider Tax ID # or SSN
From:	To:				
Calculate Total					

DEPENDENT CARE PROVIDER'S VERIFICATION: I certify that the above charges are accurate as described

Provider Name: _____ Tax ID or SSN: _____

Address: _____

Provider's Signature: _____ Date: _____

Please Note: The daycare provider must declare this as income on their tax return.

Employee Certification

By signing this form I certify that the expenses for reimbursement listed above were incurred during the time specified for the care of a qualified dependent(s) under the age of 13, or for a qualified dependent(s) who is incapable of self care. I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source, and will not be claimed as an income tax deduction when filing an income tax return.

Employee Signature: _____ **Date:** _____

Internal Use Only: **Date Received:** _____ **Date Entered:** _____