ACKNOWLDEGEMENT OF FIXED PAYMENTS

Dependent Care Spending Account

For Whitfield 3073000

I, (Provider)_____________________ hereby certify that (Employee)_______________________

Is paying $_______________ per _______________ For Dependent Care Services for the period of

(Effective Date)_____________________ through (End Date) ____________________________

Dependent's name_____________________________Relationship_______________DOB_______________

Dependent's name_____________________________Relationship_______________DOB_______________

Employee Address - ____________________ City - ___________ St______________ Zip_________

Employee ID or SS#-_________________

Provider Representative____

Address____

City _________________________________State ______________Zip Code _________________

Tax ID or Social Security Number ____

Date ____

Employer Plan Services, Inc. will rely upon information provided by the Participating Employee, and shall not be liable for the completeness or truth of any information supplied. Employer Plan Services, Inc. shall have no obligation to any Participating Employee for any act, or failure to act provided Employer Plan Services, Inc. has acted in good faith in exercise of its powers as Claims Administrator of the Plan. The Participating Employee is responsible to maintain appropriate records and receipts for claims made under provisions of the Plan. Participating Employee may be required to supply proof of claims in the form of receipts or canceled checks. The Internal Revenue Service will also require verification in case of individual tax audit.

All completed forms should be returned to:

Employer Plan Services, Inc.
2180 North Loop West, Suite 400
Houston, Texas 77018

Phone: 800-447-6588/713-351-3534
Fax: 713-365-9524
FSAclaims@epsitpa.com