DEPENDENT CARE EXPENSE
REIMBURSEMENT VOUCHER

Employer Name **Whitfield**	Group No. **3073000**
Employee Last Name, First	Date of Birth
Street Address, City & State	Zip Code
Phone Number	Employee Identification Number

DEPENDENT CARE EXPENSE (Day Care Only)

Dependent's name_____Relationship_____DOB_____
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Attach receipts from provider with the name of the day care provider, address, social security and/or tax ID number, date(s) of care, and amount. If the receipts do not include the information listed, please have the provider complete the following:

Date(s) of care: _____
Day Care Provider Name: _____
Address: _____
City, State, & Zip: _____
Telephone Number: _____
Social Security and/or Tax ID Numbers: _____

Provider Signature: _____ Date: _____

Note: Should the amount of the requested reimbursement for Dependent Care exceed the amount available in the participating Employee's Dependent Account, only the Dependent Care Account balance will be paid. Any difference will be processed as Dependent Care contributions are received.

Amount Requested

$_____

_____
Signature *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.

To file a claim:
1. Complete the form
2. Attach receipts
3. Fax or mail to :

EMPLOYER PLAN SERVICES, INC.
2180 NORTH LOOP WEST #400
HOUSTON, TX 77018
PHONE: (800)447-6588/(713) 351-3534
FAX: (713)365-9524
FSAclaims@epsitpa.com