

DEPENDENT DAY-CARE REIMBURSEMENT CLAIM FORM

How to file a claim:

Reimbursement can only be made when one of the following IRS-required items is included with this claim form.

- 1) This form completed with the Provider of Care's signature as indicated below; or
- 2) Itemized receipts from the Provider of Care; or
- 3) Cancelled checks for payment to Provider of Care

By Mail: Mid American Group, Inc., P.O. Box 482, Westmont, IL 60559

By Fax: 630-789-9421

By E-Mail: flexclaims@midamgroup.com

YOUR INFORMATION:

YOUR EMPLOYER:	
YOUR NAME:	
YOUR ADDRESS:	
YOUR SSN:	- -

DEPENDENTS:

Name:	Date of Birth:	/	/	/
Name:	Date of Birth:	/	/	/
Name:	Date of Birth:	/	/	/

PROVIDER OF CARE:

Name:	Social Security or Tax ID#:
Name:	Social Security or Tax ID#:

Date(s) of Service:	Cost of Expense:
	\$
	\$
	\$
	\$
TOTAL:	\$

Provider of Care Signature:

PAYMENT AUTHORIZATION

I request payment from my Reimbursement Account for the expenses itemized and attached, and understand that the expenses reimbursed cannot be claimed on my personal income tax return. I certify that all of these expenses have not and will not be paid by any other plan or program of any employer or other person.

Employee Signature**:	Date: / /
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** By typing your name above you certify the above statement is true