CRIDER INSURANCE SERVICES

6300 Ridglea Place Suite 315 Fort Worth, TX 76116
(800) 466-2324 * (817) 735-8304 * Fax (817) 735-8301

DEPENDENT CARE CLAIM FORM

Social Security No:_____

Participant's Name:_____

To: Crider Insurance Services – Plan Administrator

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts, and invoices for all expenses claimed) in the amounts below: (If additional space is needed, please use the back of this form.)

1. NAME OF DEPENDENT(S):

_____

_____

2. PERIOD COVERED FROM _____ TO _____
MONTH/DAY/YEAR MONTH/DAY/YEAR

3. Name, Address and Taxpayer Identification number of person providing service and description of service:

Amount $ _____*

* 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 earnings of $200 is there is one (1) child or dependent, and $400 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 or stepchild and is under age 19.

PLEASE READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the employer's Cafeteria Plan with respect to such expenses and the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a prior expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Employee's Signature Date

For Plan Administrator Use:
Payment Authorized:_____ Check No._____
Amount $_____ Date:_____