MEDICAL MUTUAL SERVICES®
A MEDICAL MUTUAL COMPANY

FlexSave
MZ: 04-2W-8317
2060 East Ninth Street
Cleveland, Ohio 44115-1355
Phone Number: (800) 525-9252
Fax Number: (440) 878-4890

Dependent Care Expense Claim Form

Instructions

Complete as many entries as you need for dependent care expenses, then sign and date the bottom of the form. Send completed form along with a fully detailed receipt showing the period covered (dates of care), description of services and amount charged. You can fax the completed form to (440) 878-4890 or mail it to the address above. If you have questions, please call Customer Care at (800) 525-9252. We are available Monday through Friday from 8 a.m. to 5 p.m. Please feel free to make copies of this form for future use.

General Information

Employer	Employee Name	Phone Number

Dependent Care Expense Claims

Service Provider Name	Service Provider Address	Taxpayer ID Number

Name of Dependent	Period Covered	Amount Incurred
	/ / to / /	
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	/ / to / /	
		Total Amount

Dependent Care Provider Certification (Necessary only if receipt is not provided)

I certify that the services for the above noted service period(s) and cost(s) have been incurred by the claimant and that I have not previously certified these expenses.

Dependent Care Provider's Signature	Date

Certification and Authorization

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred to enable myself, and if married, my spouse to be gainfully employed while I was a participant in the plan. I have already received these products and services and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the plan(s) for any such expense or for payment of all related income taxes on amounts paid from the plan(s) which relate to such expense. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans. I also certify that if I am requesting reimbursement for work-related dependent care expenses incurred for care provided by a valid dependent care provider to an eligible dependent (for children under the age of 13 or other dependents that are physically or mentally incapable of taking care of themselves) it was while I was a participant in the plan.

Employee Signature	Date