DEPENDENT CARE

RECEIPT FORM

TO: (YOUR NAME): ______________________________

(YOUR EMPLOYER): ______________________________

By the signature below, I certify that the total of $ ____________ for the month(s) or week(s) of ______________________ has been received for Dependent Care Expenses for the following person(s):

Name: ______________________ Age/Date of Birth: ____________

Name: ______________________ Age/Date of Birth: ____________

Name: ______________________ Age/Date of Birth: ____________

This documentation will serve as a receipt for Dependent Care expenditures.

(Please have your Dependent Care Provider Sign this receipt).

FROM: ______________________________
Signature of Dependent Care Provider

____
Dependent Care Provider Tax Id or SS #

____
Date

FORM PROVIDED BY:

Southern Administrators and Benefit Consultants, Inc.
P.O. Box 2449
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