

**COREFLEX**  
**Annualized Dependent Care Reimbursement Form**

To help eliminate the need for multiple reimbursement requests throughout the year, we are offering annualized dependent care reimbursement. By completing this form you will automatically be reimbursed from your dependent care account as funds become available throughout the year. Please note that it is your responsibility to immediately report any changes you may have regarding the information below.

Employer: \_\_\_\_\_  
Employee name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Dependent's Full Name: \_\_\_\_\_ Dependent's Date of Birth: \_\_\_\_\_  
Dependent #2 \_\_\_\_\_  
Dependent #3 \_\_\_\_\_  
Dependent #4 \_\_\_\_\_

Caregiver's name and address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Caregiver's SSN or ID#: \_\_\_\_\_

Amount paid per week: \_\_\_\_\_

Signature of Caregiver: \_\_\_\_\_

I certify that the following is true:

1. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
2. The expenses listed above were incurred by my eligible dependents and qualify for reimbursement.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to:

**CoreSource**  
Attn: Flexible Spending Department  
P.O. Box 8215  
Little Rock, AR 72221  
Phone: 877-267-3359  
Fax: 501-221-9074