CONTRACT FOR SERVICES
Dependent Care Reimbursement Account

Employer's Name: ______________________________

Participant Name: ______________________________
Last First Middle

Social Security Number: __________ - __________ - __________

Address: ______________________________
Street

__________ __________ __________ __________
City State Zip Code Phone Number

This is to certify that I have entered into an agreement with the provider listed below to receive Dependent Care Services.

Full Name of Dependent: ______________________________
Dates of Service: From: __________ To: __________
Annual Cost of Service: $ __________ Weekly Cost of Service: $ __________
Name of Dependent Care Provider: ______________________________
Last First

Provider's Address: ______________________________
Street

__________ __________ __________ __________
City State Zip Code Phone Number

Provider's Social Security or Tax ID Number: ______________________________

I understand that I must keep all canceled checks and receipts for services rendered and that the plan administrator, Self Funding Administrators, may periodically request copies to verify expenses. I further understand that the above expenses are ones that I must pay for out-of-pocket, because they are not covered, have not been reimburse and are not reimbursable under any other Dependent Care coverage. I agree to submit any such information requested as proof of payment. I acknowledge that it is my responsibility to notify the plan administrator, Self Funding Administrators of any change to this Contract for Services. Furthermore, I understand that it is my responsibility to file a Form 2441 when I file my tax return.

Participant's Signature: ______________________________ Date: __________

Provider's Signature: ______________________________ Date: __________