



### STATEMENT OF DEPENDENT CARE EXPENSE

*Submit this form, along with a completed claim form, to Benefit Resource, Inc.*

Name of Employee *(please print clearly)*: \_\_\_\_\_ Date: \_\_\_\_\_

Dependent care services were provided for \_\_\_\_\_

by \_\_\_\_\_

for services provided on the dates \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_.

Cost of these services: \$ \_\_\_\_\_

\_\_\_\_\_  
*Name of Provider (please print clearly)*

\_\_\_\_\_  
*Provider Signature*

*(separate here)*  
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