Dependent Care Reimbursement Request Form **(DAY CARE)**

Submit claims to: Varipro Benefit Administrators
Flexible Spending Department
5300 Patterson SE Suite 150
Grand Rapids, MI 49512

or

Fax (855) 296-1026/Number of pgs____
Email claims to: flex@varipro.com

o r

Log into myRSC.com and submit claims online

For questions please call: (616) 285-2480 or (800) 732-3412

Employee Instructions:

1. Reimbursement forms must be complete and clear. Failure to answer any questions or provide proper documentation may delay payment.
2. All receipts must have the name of the dependent(s), date of service, a provider, and the amount of the charge.
3. You must provide bills from your dependent care provider or other evidence that the expenses were incurred and paid. Cancelled/Copied checks will not be accepted.

Employer\Place of employment_____Kent County_____Department _____

Employee Name_____Date of Birth_____

Street Address_____

City_____State_____Zip Code_____

☐ Change of Address

Employee Number_____ or Social Security Number (Optional)_____

Provider Information:

Name of Provider_____SS# or Tax ID of provider_____

Address of Provider_____

Dates of Service: From_____Through_____

Name of Dependents:	Age (under 13)
1_____	_____
2_____	_____
3_____	_____

TOTAL REIMBURSEMENT REQUESTED $_____

To the best of my knowledge and belief, this Reimbursement Request Form is complete and true. The expense is for my dependent. I certify that the receipts are for a dependent as defined in the plan. I certify that I have not been reimbursed previously for these expenses. I understand that these expenses may not be used to claim any federal income tax deduction or credit (including the dependent care tax credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. I authorize a deduction from my Dependent Care Reimbursement Account in the amount of this reimbursement request.

_____ _____

Employee Signature Date