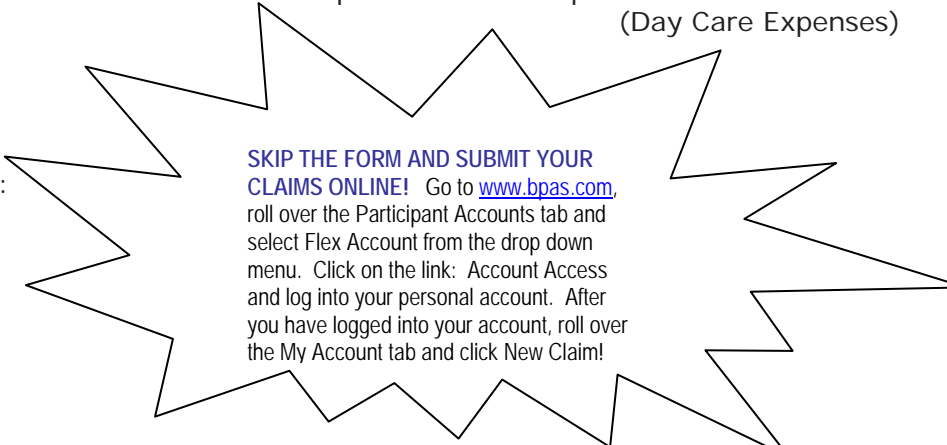




Dependent Care Request For Reimbursement
(Day Care Expenses)

When completed, mail this form and receipt to:

Flex Corp
820 Gessner, Suite 1225
Houston, Texas 77024
Phone: (866) 401-5272
Fax: (866) 254-2942



SKIP THE FORM AND SUBMIT YOUR CLAIMS ONLINE! Go to www.bpas.com, roll over the Participant Accounts tab and select Flex Account from the drop down menu. Click on the link: Account Access and log into your personal account. After you have logged into your account, roll over the My Account tab and click New Claim!

Employer Name: _____

Employee Name: _____

Social Security #: _____ or Alternate ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

If this is a new address, please indicate by checking the box.

Dependent Information:

Name: _____ Date of Birth: _____ Age: _____ Relationship: _____

Name: _____ Date of Birth: _____ Age: _____ Relationship: _____

Name: _____ Date of Birth: _____ Age: _____ Relationship: _____

Name: _____ Date of Birth: _____ Age: _____ Relationship: _____

Name: _____ Date of Birth: _____ Age: _____ Relationship: _____

Period Covered From: _____ To: _____ Amount: \$ _____

Attach a receipt or complete the following:
Received \$ _____ on _____ from _____
(amount) (date) (parent/guardian)
for the care of the child(ren) indicated above, for the period of time indicated above.

Original signature of day care provider

Receipts or bills for dependent care should include the name and address of the day care provider, the name(s) of the person(s) receiving the care, the period of time during which the care was provided, and an itemized statement of the charges.

Please reimburse the above expenses from my dependent care reimbursement account in accordance with current guidelines. I certify that these expenses have not been reimbursed nor are they reimbursable from any other source.

Employee Signature

Date