412 Water Street, Sioux City, IA 51103
Phone: 712-277-2424/800-763-1897
Fax: 712-277-2622
www.ibcins.biz

DEPENDENT CARE REIMBURSEMENT REQUEST

Employer Name		
Employee Name	Employee Phone #	
Employee Address		☐ New Address
City	State	Zip

Dependent Care Expense

Period Beginning	Period Ending	Total Amount Requested for Reimbursement	Total Charge	Amount to Be Reimbursed

Signature of Service Provider:_____ Date:_____

**Amount reimbursed from Dependent Care Expense account cannot exceed the amount employee has contributed to date. You must either ask your provider to sign this request for reimbursement or provide a receipt from your provider.*

I hereby request payment from my flexible spending account for the expenses listed above. I certify that I have not been reimbursed for the expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim on federal income tax deduction or credit. I hearby authorize deduction from my flexible spending account.

Employee Signature:_____ Date: _____

*****FAX COMPLETED FORM & SUPPORTING DOCUMENTS TO (712) 277-2622 or email claims@ibcins.biz. Retain original documents for your records.***