

CORESOURCE*A Trustmark Company***COREFLEX****Annualized Dependent Care Reimbursement Form**

Phone: 1-877-267-3359

Fax: 1- 501-221-9074

*****PLEASE NOTE IF ADDRESS IS A NEW ADDRESS*****

A. EMPLOYEE INFORMATION

Name	Social Security Number	Employer Name	
Address (ONLY IF NEW)	City	State	Zip
		Email Address: <i>(optional)</i>	

To help eliminate the need for multiple reimbursement requests throughout the year, we are offering annualized dependent care reimbursement. By completing this form you will automatically be reimbursed from your dependent care account as funds become available throughout the year. Please note that it is your responsibility to immediately report any changes you may have regarding the information below.

Dependent #1 Full Name	
Dependent #2 Full Name	
Dependent #3 Full Name	
Dependent #4 Full Name	

Caregiver's Name & Address:	
Caregiver's SSN or ID#:	

Amount DUE in Dependent (DAYCARE) Expenses per week:

Signature of CAREGIVER:

I certify that the following is true:

- I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
- The expenses listed above were incurred by my eligible dependents and qualify for reimbursement.

EMPLOYEE SIGNATURE:

Please return this form to:

CoreSource**ATTN: COREFLEX- Flexible Spending Department****P.O. Box 8215****Little Rock, AR 72221****Phone: 877-267-3359****Fax: 501-221-9074**