DEPENDENT DAYCARE CLAIM FORM

SECTION 125 -REIMBURSEMENT ACCOUNT PLAN

IPMG
INSURANCE PROGRAM MANAGERS GROUP

HOW TO FILE A CLAIM

1.) Reimbursement can only be made with the submission of one of the following:

a. this form completed with the Provider of Care's signature as indicated below including the tax id #; or,
b. itemized receipts completed by the Provider of Care attached to this claim form
c. cancelled checks with date corresponding to the dates of service.

2.) **Mail your claim to:** IPMG Employee Benefits Services
225 Smith Rd.
St. Charles, IL 60174
Phone: 630-789-2082

Fax: 630-203-4580

Website Submittal and/or E-mail:
www.ipmg.com/ebs

ABOUT YOU

Employer's Name _____

Your Name _____

Your Address _____

Phone #/E-mail_____

Your Alternate-ID* or Social Security Number_____

*Your Alternate-ID is assigned by IPMG

DEPENDENT INFORMATION

Name:	***Date of Birth:***

DAYCARE PROVIDER INFORMATION

Name:_____ Social Security/Tax ID#:_____

Date of Service:	***Amount:***

_____

Provider of Care Signature

PAYMENT AUTHORIZATION

I request payment from my Reimbursement Account for the expenses itemized and attached, and understand that the expenses reimbursed cannot be claimed on my personal income tax return.

Employee Signature _____ Date _____