Penn Medicine Lancaster General Health

MyBenefits

# LG HEALTH/COREFLEX
# Annualized Dependent Care Reimbursement Form

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.

Employer: _____

Employee name: _____ Social Security Number: _____

Dependent's Full Name _____ Dependent's Date of Birth: _____

Dependent #2 _____ _____

Dependent #3 _____ _____

Dependent#4 _____ _____

Caregiver's name and address: _____

_____

_____

Caregiver's SSN or ID#: _____

Amount paying per week: _____

Signature of Caregiver: _____

I certify that the following is true:

1. I have not and will not deduct, on my Federal Income Tax returns, the portion of the above listed expenses which will be reimbursed through my Flexible Spending Account; and
2. The expenses listed above were incurred by my eligible dependents and qualify for reimbursement.

Employee Signature: _____ Date:_____

Please return this form to:

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