Flexible Spending Recurring Expense Service Form

INSTRUCTIONS: This form is used to request your Dependent Care Account or Transportation Account contributions be reimbursed to you on a per pay period basis. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation stating your dependent will be attending throughout the year or specific time frames. All **information** must **be completed by you** & **your Dependent Care provider to receive reimbursement.** CLAIMS WILL NOT **BE PROCESSED WITHOUT** YOUR **SIGNATURE** AND **THE PROVIDER'S SIGNATURE.**

A. Declaration of Services

I request reimbursement for the below listed timeframe for qualified

† Dependent Care Services **or** † Transportation Expenses

I certify that the services will be provided between the following dates:

_____ to _____

Start Date of Services (MM/DD/YY) End Date of Services (MM/DD/YY)

I have included signed copies of the independent provider's charges, which will include the total amount of $_____for the dates provided above.

Total Amount of Services

NOTE: If you have any changes during the dates referenced above, please notify TML IEBP at (800) 282-5385 or fax (512) 719-6505

B. Participant Information

Name of Participant	Social Security Number		
Address: Street	City	State	Zip
Phone Number	E-Mail		
Name of Dependent			

C. Care Provider Information

Name of Dependent Care/Transportation Expense Provider			
Address: Street	City	State	Zip
Federal Tax ID			

D. Signatures

_____ _____

Authorized Signature of Provider Date

_____ _____

Participant Signature Date

PLEASE NOTE: Your total reimbursement **amount** will **be** figured **on** the **amount** which you have elected for the year based on the amount of payrolls that occur throughout **the plan** year. For questions regarding your maximum contribution amount, **please** contact **TMLIEBP at (800) 282-5385 or fax (512) 719-6505.**