ASURESOFTWARE

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CONSTANT REIMBURSEMENT FORM

QUALIFIED DEPENDENT CARE SERVICES ON A CONTRUCTUAL OR CONSTANT BASIS.

The Provider below hereby certifies that the expenses described below for the qualified dependent care services will be incurred by the claimant pursuant to a contract or for the constant and continuous amount stated herein.

Provider's Name: _____

NAME OF DEPENDENT(S) FOR WHOM CARE IS PROVIDED FOR (List on line below)

_____ _____

_____ _____

PERIOD OF WHICH EXPENSES ARE INCURRED Start Date: _____ End Date: _____

AMOUNT TO BE INCURRED PER PLAN YEAR $ _____

☐ I hereby certify the above information to be true and correct.

_____ _____

Signature of Provider or Representative Date

CLAIMAINT'S STATEMENT

☐ I understand that this certification is submitted to verify certain expenses incurred by me for reimbursement under my employer's qualified dependent care assistance plan. I agree to notify my employer immediately of any change or modification of any of the information contained herein.

_____ _____

Claimant (Employee) Signature Date

_____ _____

Claimant's Social Security Number Employer

RETURN THIS COMPLETED FORM TO:

Asure Software
945 Lakeview Parkway Suite 170
Vernon Hills IL 60061
Fax: 224-433-5229
Email: processingteam@emangrove.com