Print Form

Dependent Care Claim form

CAS
Consolidated Admin Services

P.O. Box 1513
Cabot, AR 72023
Phone: 501-941-5956
Fax: 877-641-5956
info@consolidatedadmin.com
www.consolidatedadmin.com

Date

Employer

SSN

First Name

Last Name:

Address:

☐ Check here if new address

Please Itemize each expense on form provided, if you have more expenses than form allows please attach separate form.

Date of Service	Dependent Name & Age	Provider Name, Tax Id & Address	Amount

Total Expense

Please have your day care provider sign this form on the line below or provide a receipt for the services

Signature of day care provider:_____

I certify that the statement and information on this claim form are accurate and true.
I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and are for eligible participants.
I certify that these expenses have not been or will not be reimbursed from any other source.
I assume all liability for taxes and penalties out of any disallowed contribution/reimbursement

Signature:

Date:

Mail claims to: P.O. Box 1513, Cabot AR 72023; Fax claims to: 877-641-5956; or E-mail claims to: info@consolidatedadmin.com
For questions regarding your claims please call: 501-941-5956