

## MyFlex Dependent Care Information

Employer	Date:
Employee Name:	SSN#
Dependents for whom care will be provided: _____	
The provider charges a set amount of \$ _____ per: ___ Week ___ Bi-weekly ___ Monthly ___ Hour ___ Other _____	
Rates are effective for ____ / ____ / ____ to ____ / ____ / ____	
Provider's Name	Tax ID#
Provider's Signature:	

Once Health Choices has your **Dependent Care Information** sheet on file you will not need to continue submitting day care receipts with your claim form. Simply provide the dates of service, the name of the dependent, and the amount paid on your claim form. Also, please note on your claim form that you have a contract on file.

**Some examples of ELIGIBLE expenses:**

- Day Care Centers
- Elder Care
- Family Child Care
- Day Camps
- Preschool
- After School Care
- Nanny/Au Pair

**Some examples of INELIGIBLE expenses:**

- Transportation fees
- Meals
- Overnight camps
- Diapers
- Educational expenses, including Kindergarten
- Incidental fees, such as activity fees and field trips