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MyFlex Dependent Care Information

Employer	Date:
Employee Name:	Employee 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.

<p>Some examples of ELIGIBLE expenses:</p> <ul style="list-style-type: none"> • Day Care Centers • Elder Care • Family Child Care • Day Camps • Preschool • After School Care • Nanny/Au Pair 	<p>Some examples of INELIGIBLE expenses:</p> <ul style="list-style-type: none"> • Transportation fees • Meals • Overnight camps • Diapers • Educational expenses, including Kindergarten • Incidental fees, such as activity fees and field trips
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