ASURESOFTWARE

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CONSTANT REIMBURSEMENT CONTRACT

QUALIFIED DEPENDENT CARE SERVICES ON A CONTRACTUAL OR CONSTANT BASIS.

The Provider below hereby certifies that the expenses described below for 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: _____ Date: _____

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

_____ _____

_____ _____

PERIOD OVER 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**

CLAIMANT'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 Signature **Date**

___ – ___ – ____ _____

Claimant's Social Security Number: **Employer**

RETURN THIS COMPLETED FORM TO:
Asure Software
Address Line One
City, ST ZipCode
Email: