Note: This form contains interactive fields. Click above the Employee Name field, then use the TAB key to move to the next field

DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYER NAME: City of South Bend

Employee Name

Social Security Number

Street Address (Apt. No.)

City State Zip

☐ Check if Name Change ☐ Check if Address Change

SEND CLAIMS TO:

NORTH AMERICA ADMINISTRATORS, L.P.
P. O. BOX 1984
NASHVILLE, TN 37202

PHONE: 615-256-3561 or 800-411-3650
FAX: 615-255-6654; EMAIL: claims@naa-lp.com

Please enter information for which claim is being made in appropriate sections.

EXPENSES TO BE REIMBURSED: **Dependent Name:** _____

Dates of Service From	To	Provider Name, Tax ID No., Address	Amount Requested
\\	\\		$
\\	\\		$
\\	\\		$
\\	\\		$
\\	\\		$
\\	\\		$
\\	\\		$
\\	\\		$

The Total Amount Requested field will automatically provide a total.

TOTAL AMOUNT REQUESTED: $_____

IMPORTANT: YOU MUST PROVIDE A RECEIPT FROM THE PROVIDER OF SERVICE.

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the dates noted.

SIGNATURE:_____**DATE:**_____

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