East End Health Plan

DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM EXTENSION FORM

This form must be attached to a completed Request for Reimbursement Claim Form not acceptable alone.

DEPENDENT CARE CLAIM INFORMATION:

Date of Service From mo/day/yr to mo/day/yr.	For the Benefit of (Name & Relationship)	Provider of Services	Requested Amount
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Total amount of medical expenses to carry over to the Request for Reimbursement Claim Form $_____

Employee Signature: _____ Date: _____