HIGGINBOTHAM

DEPENDENT CARE SPENDING ACCOUNT
Reimbursement Form

Employer Name _____

Employee Name _____

Employee SSN _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-mail _____

Child(ren) Name(s) _____

Date(s) of Service _____ Charge(s) _____

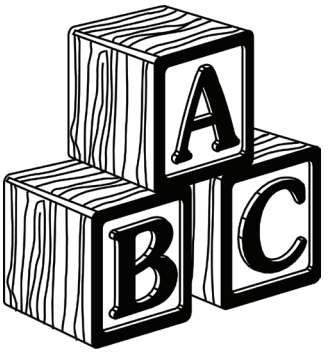
Name and Address of Facility or Provider _____

Provider's Tax I.D. or Social Security Number _____

Signature of Provider _____

The dependent care expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other dependent care plan, including other dependent care flexible spending arrangements.

Employee Signature _____ **Date** _____



Fax or mail to:

Attn: Flex Department
c/o Higginbotham
500 W. 13th Street
Fort Worth, TX 76102
Phone: 866-419-3519
Fax: 817-882-9267
Toll-Free Fax: 866-419-3516
E-mail: flexclaims@higginbotham.net