# Statement of Expense

## DEPENDENT CARE

Submit this form, along with a completed claim form, to Benefit Resource, LLC.

Employee Name

Date *(MM/DD/YYYY)*

Dependent care services were provided for *(name of dependent(s)):*

by *(name of person/company providing the care):*

for services provided on the dates ____ / ____ / ____ through ____ / ____ / ____

Cost of these services: **$**

Name of Person Providing Care

Signature of Person Providing Care