

**The BESTflex<sup>SM</sup> Plan**  
Section 125 Administration

Company Name ^ \_\_\_\_\_ Today's Date \_\_\_\_\_

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Dependent(s) Name(s) \_\_\_\_\_

**Daycare Expenses Receipt and/or Contract**

Provider's Name \_\_\_\_\_ Provider Tax ID # or Social Security Number \_\_\_\_\_

**The provider charges a set amount.**

**\$** \_\_\_\_\_ **per:**  Week  Bi-Weekly  Month  Other \_\_\_\_\_

Describe Other \_\_\_\_\_

**These rates are effective for the period of**

Month/Day/Year \_\_\_\_\_ Through \_\_\_\_\_ Month/Day/Year \_\_\_\_\_

**The provider charges per hour.**

This is to certify that \$ \_\_\_\_\_ is the charge for the period:

Month/Day/Year \_\_\_\_\_ Through \_\_\_\_\_ Month/Day/Year \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_



**Web Address:**  
www.ebcflex.com

**U.S. Mail:**  
Employee Benefits Corporation  
PO Box 44347  
Madison WI 53744-4347

**Phone:**  
Monday - Friday, 8:00 - 5:00  
608 831 8445  
800 346 2126

**Fax:**  
608 831 1159  
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