

# The BESTflex Plan

Section 125 Administration

Please submit this receipt in conjunction with your completed BESTflex Plan Reimbursement Form.

Participant Name \_\_\_\_\_ Last 4 digits of Social Security or Identification Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Today's Date (mm/dd/yyyy) \_\_\_\_\_

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

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

This is to certify that \$ \_\_\_\_\_ was charged for services incurred:

Date (mm/dd/yyyy) \_\_\_\_\_ Through \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

**X**  
Provider's Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

## Daycare Expenses Receipt

1

### For Employee Benefits Corporation Use Only

Group ID Number \_\_\_\_\_

Specialist \_\_\_\_\_

Processed Date \_\_\_\_\_

**Employee Benefits Corporation**

**Web Address:**  
www.ebcflex.com  
  
1226-1110

**U.S. Mail:**  
Employee Benefits Corporation  
PO Box 44347  
Madison WI 53744-4347  
  
© 2010 Employee Benefits Corporation

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

**Fax:**  
608 831 4790



# The BESTflex Plan

Section 125 Administration

Please submit this receipt in conjunction with your completed BESTflex Plan Reimbursement Form.

Participant Name \_\_\_\_\_ Last 4 digits of Social Security or Identification Number \_\_\_\_\_

Employer Name \_\_\_\_\_ Today's Date (mm/dd/yyyy) \_\_\_\_\_

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

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

This is to certify that \$ \_\_\_\_\_ was charged for services incurred:

Date (mm/dd/yyyy) \_\_\_\_\_ Through \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

**X**  
Provider's Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

## Daycare Expenses Receipt

1

### For Employee Benefits Corporation Use Only

Group ID Number \_\_\_\_\_

Specialist \_\_\_\_\_

Processed Date \_\_\_\_\_

**Employee Benefits Corporation**

**Web Address:**  
www.ebcflex.com  
  
1226-1110

**U.S. Mail:**  
Employee Benefits Corporation  
PO Box 44347  
Madison WI 53744-4347  
  
© 2010 Employee Benefits Corporation

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

**Fax:**  
608 831 4790