

Dependent Care Acknowledgement Form



Febco Benefits Administration

Participant Information

Employer Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____ Birthday: _____

Dependent Information

1 Dependent Name: _____ Birthdate: _____

2 Dependent Name: _____ Birthdate: _____

3 Dependent Name: _____ Birthdate: _____

4 Dependent Name: _____ Birthdate: _____

Daycare/Private Sitter Information (To be completed by your Daycare provider/Private sitter)

Service Start Date: _____ Service End Date: _____

Amount received or will receive: \$ _____ (Weekly - Bi-weekly - Monthly)

Private Sitter Social Security or tax Id: _____

Private Sitter Name (Please Print) _____

Private Sitter Signature: _____

Date: _____

Daycare Name: _____

Daycare Tax ID: _____

Dependent Care Representative Signature: _____

Date: _____

Signature *(Incomplete forms will not be processed)*

Employee Signature: _____ Date: _____

Fax this form to: (502) 695-9692

Febco Benefits Administration
PO Box 5010
Frankfort, KY 40602

www.febco.com

Form: DEPENDENTCARE02122015

Customer Service: 1-800-489-1539