WIMBERLY ASSOCIATES, INC.

Dependent Care Receipt

Employee Name: ______________________________________

Dependent's Name: ____________________________________

Employer: ____

Employee SSN: _______________________________________

Service Provider: _____________________________________

Date(s) Service Rendered: _______________________________

Amount Paid: $____

Received for the care of the above dependent for the period stated.

Provider's Signature: ___________________________________

Date: ______________

Please Fax, Email or Mail to:
Wimberly Associates, Inc.
150 Cunningham Pond Rd.
Peterborough, NH 03458
Fax: 888-653-6034
Claims@wimberlyassociates.com