MANN FINANCIAL, INC.
FLEXIBLE BENEFIT PLAN

DEPENDENT CARE CLAIM FORM

Employee Social Security Number: _____ Daytime Phone: _____

Participant's Name:_____
Last First Middle

The undersigned participant in the Plan requests reimbursement (**attach itemized bills, receipts and invoices for all expenses claimed**) in the amounts shown below:

1. Name of Dependent(s)_____

2. Period Covered: From_____ through _____

3. Service Provider Information:

   Name:_____

   Address:_____

   _____

   Taxpayer ID # (Social Security Number):_____

   Amount $_____

NOTE:

The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan year or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for Federal income tax purposes, or is your child or stepchild and is under age 19.

Adequately documented claims will be processed within three working days of receipt. Claims may be sent to:

Employee Benefit Resources, LLP
P.O. Box 1193
Helena, MT 59624
(406) 449-5500 or (800) 765-9429
Fax: (406) 442-5089

Complete both sides of this form and sign where indicated.

For Plan Administrator Use Only Claim Numbers _____ _____ _____ / _____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the **Mann Financial, Inc. Flexible Benefit Plan** with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including Federal, State or City income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

_____ Date_____

Employee's Signature

CHILD CARE PROVIDER STATEMENT
Mann Financial, Inc. Flexible Benefit Plan

I have received $_____ (amount received) from _____ (participant) for the care of _____ (dependents) during the period from _____ to _____ (dates).

_____ Date_____

Child Care Provider Signature