

FSA Dependent Care Reimbursement Form

Take advantage of email updates on the status of your claims and reimbursements. It's easy!
Just login to **flexiblebenefit.com** and update your profile to select e-communications.

Date: _____
Fax- # of Pages: _____

Please follow the steps below to thoroughly and accurately complete this form.

Step 1: Personal Information

Company Name: _____
Employee Name: _____ SSN: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email Address: _____

Step 2: FSA Dependent Care Claims

Date Span of Service (mm/dd/yy)	Name of Provider	Provider Tax ID/SS#	Dependent Date of Birth	Description of Service & Dependent Name	Claim Amount
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
Total:					\$ _____

Step 3: Provider Affidavit:

I hereby certify that the above Dependent Care charges have been incurred. Receipts are not required if the Dependent Care provider signs this section.

Provider Signature: _____ Date: _____

Step 4: Acknowledgement and Signature

I acknowledge that my statements in this request for reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or other benefit plans and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount(s) requested.

Employee Signature: _____ Date: _____

Claim Submission Instructions:

Option 1: Submit a Reimbursement Request online and Go Paperless! You won't need to complete paper forms anymore. Submit claims online at **flexiblebenefit.com**.

Option 2: Submit a Reimbursement Request in four easy steps using this form.

1. Provide acceptable proof of paid expenses. We request that you send **Copies** of your proof of expenses since they will not be returned to you. For tax purposes, you should retain the original proof of expense. Please provide a copy of a 3rd party statement and/or receipt referencing the following information: date span of service, type of service, dollar amount paid, dependent name and provider's tax ID# or SSN. Neglecting to submit required documentation may delay claim processing.
2. Write the total amount for reimbursement in the claim amount column.
3. Attach all documentation pertaining to your claim to this form and fax to 847-636-9295.
4. Send request for reimbursement via fax, mail or email.

Note: To update your email address and other contact information, please login to **flexiblebenefit.com**



GO PAPERLESS!

You can login to your account at **flexiblebenefit.com** and submit your claims online without needing to complete any paper forms. Get started today!

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