

Dependent Care Flexible Spending Account (FSA)
Reimbursement Form



PARTICIPANT INFORMATION			
ID NUMBER OR SSN	LAST NAME	FIRST NAME	M.I.
EMPLOYER NAME		EMPLOYER ID/CLIENT CODE	
HELPFUL TIPS			
<ul style="list-style-type: none"> • Each expense must be accompanied by supporting documentation. Your supporting documentation may consist of receipts from the provider (complete Section A), OR you may ask the provider to complete and sign SECTION B of this form. • We cannot process dependent care requests before the first date of the actual service. Please do not submit your claim before the first date of service to avoid denial/delay in reimbursement. • Make copies of your supporting documentation. Submit the copies and retain the originals for your records. Please do not highlight items or staple receipts. 			
STEP #1 – Complete either SECTION A or SECTION B below			
SECTION A			
Use this section if you have receipts from your dependent care provider(s)			
DATE OF SERVICE	PROVIDER	DEPENDENT NAME	AMOUNT
From: / /			\$
To: / /			
From: / /			\$
To: / /			
From: / /			\$
To: / /			
SECTION B			
Use this section as your documentation by having the provider complete and sign.			
DEPENDENT CARE PROVIDER SIGNATURE			
X			
Dependent Care Provider's Name			SSN or Tax ID#
Date of Service (include year) From: / / To: / /			Amount of Service \$
STEP #2 – Sign the form			
By submitting this form, I attest and agree to the following: To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable coverage period for myself and/or my legal dependent(s) under the plan. I certify that these expenses have not previously been reimbursed or will not be reimbursed under any other benefit plan, and will not be claimed as an income tax deduction.			
EMPLOYEE SIGNATURE (Required)			DATE
X			
STEP #3 – Make copies of the supporting documentation			
STEP #4 – Submit signed form(s) and copies of supporting documentation			
Fax to: 1-866-717-3820 (Please do not use a cover sheet)			
Mail claims with documentation to: REIMBURSEMENT ADMINISTRATION PO BOX 534451 ST PETERSBURG FL 33747			
For Customer Service, please call: 1-877-799-8820			