Dependent Care FSA Reimbursement Form

Page____ of____

EMPLOYEE NAME: LAST | FIRST | MIDDLE INITIAL | COMPANY NAME

LAST FOUR DIGITS OF SOCIAL SECURITY NO. | DAYTIME PHONE NUMBER | EMAIL ADDRESS ❍ check if new

HOME ADDRESS: STREET ❍ check if new | CITY | STATE | ZIP

To the best of my knowledge and belief, my statements for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction or credit. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

X

EMPLOYEE SIGNATURE VERIFICATION (Receipts will not be processed without signature) **DATE**

STEP 1: This section of the reimbursement form must be completed only for eligible expenses and only for expenses incurred during your plan year. You must have been a participant in the plan at the time the expense was incurred. The incurred date of the expense is the date of service. This form is for Dependent Care expenses only so please do not submit any Heathcare expenses with this form.

COMPLETE THIS SECTION IF YOU ARE PROVIDING RECEIPTS

Receipts must include the following information:

- ❍ Date of Service
- ❍ Provider of Service
- ❍ Service/Item Purchased
- ❍ Amount of Service
- ❍ **Be sure to total your expenses**
- ❍ **Canceled checks/credit card statements are not acceptable forms of documentation**

DATE OF SERVICE	PROVIDER	TYPE OF SERVICE	AMOUNT OF SERVICE
From: / / To: / /			$.
From: / / To: / /			$.
From: / / To: / /			$.

COMPLETE THIS SECTION IF YOU ARE NOT PROVIDING RECEIPTS

- ❍ Your provider's signature and this completed claim form will serve as your receipt.
- ❍ All fields in the section must be completely filled out for your claim to be processed.

SIGNATURE OF DEPENDENT CARE PROVIDER	
X	
DEPENDENT CARE PROVIDER'S NAME	**SSN OR TAX ID#**
DATE OF SERVICE	**AMOUNT OF SERVICE**
From: / / To: / /	

TOTAL DEPENDENT CARE EXPENSES	$.

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STEP 2: Please fax to 877-767-8804 for the quickest processing time, complete, sign and fax your reimbursement form and all necessary documentation. A cover page is not required. If you prefer to mail your form and receipts, please send to PlanSource, P.O. Box 161940, Altamonte Springs, FL 32714. Please keep all receipts and original documentation as required by the IRS.