

DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

FLEXIBLE SPENDING ACCOUNT

YOUR COMPANY NAME _____

EMPLOYEE NAME: _____

SSN: _____

ADDRESS: _____

SEND CLAIMS TO:

Group Administrators, Ltd.
Attn: FSA Administration
915 National Parkway, Suite F
Schaumburg, IL 60173
Telephone: (847) 519-1880
Fax: (847) 519-1979

Check if Name Change

Check if Address Change

INSTRUCTIONS AND HELPFUL HINTS:

- Please fill the claim form out in its entirety, making sure all information is entered in the sections below.
- Supporting documentation should include the **DEPENDENT'S NAME, THE ACTUAL DATES OF SERVICE, DESCRIPTION OF WHAT THE CHARGE IS FOR, AMOUNT PAID, AND PROVIDER'S TAX I.D.# WITH SIGNATURE.** This information must accompany this form. Acceptable documentation includes:
 - Original cancelled checks with above information included on check. The above information must be on the check prior to it being processed.
 - Signed itemized receipt from caregiver with above information.
 Please retain copies of documentation for your records as those submitted will not be returned.
- Qualified Dependents Include:
 - Dependents under the age of 13 (if care is provided outside your home, dependent must spend at least eight (8) hours per day in your home).
 - Incapacitated parent, spouse & child of any age living with you and dependent on you for at least 50% of support.
- Qualified Expenses include:
 - Those enabling you and your spouse, if applicable, to work.
 - Care already received (expenses cannot be reimbursed until after care has actually been provided).
 - A licensed daycare facility in one complying with all state laws and providing care for more than six (6) individuals other than those residing in the facility.
 - No educational expenses above the first grade qualify as dependent care. Some below the first grade may qualify if there is no distinction between the childcare expense and the educational expense.
 - Overnight camps are not an eligible expense under a Flexible Spending Account.

DEPENDENT CARE EXPENSES TO BE REIMBURSED:

	Dates of Service From	To	Care Provider Name and Address	Care Provider Tax ID or SSN	Amount Requested
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Total Amount Requested _____

EMPLOYEE CERTIFICATIONS:

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the date noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the amount that I have available in my account.

SIGNATURE: _____

DATE: _____