DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

COMPANY NAME: ____

EMPLOYEE NAME: ____

ID NUMBER: _______–_______–_______

PHONE NUMBER: ____

E-MAIL ADDRESS: ____

SEND CLAIMS TO:
Group Administrators, Ltd.
Attention: FSA Administration
953 American Lane, Suite 100
Schaumburg, Illinois 60173

Email: fsa@groupadministrators.com
Fax: (847) 519-1979

Telephone: (800) 323-1683

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT OF POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______________________ Relationship to Account Holder: ☐ Qualifying Child ☐ Qualifying Relative ☐ Spouse ☐ Other: ____________ Type of Service: ☐ Child Care ☐ Pre-School ☐ Before/After School ☐ Senior Day Care ☐ Au Pair ☐ Summer Day Camp	$______________
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______________________ Relationship to Account Holder: ☐ Qualifying Child ☐ Qualifying Relative ☐ Spouse ☐ Other: ____________ Type of Service: ☐ Child Care ☐ Pre-School ☐ Before/After School ☐ Senior Day Care ☐ Au Pair ☐ Summer Day Camp	$______________
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______________________ Relationship to Account Holder: ☐ Qualifying Child ☐ Qualifying Relative ☐ Spouse ☐ Other: ____________ Type of Service: ☐ Child Care ☐ Pre-School ☐ Before/After School ☐ Senior Day Care ☐ Au Pair ☐ Summer Day Camp	$______________

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 qualify as dependent care, including Kindergarten.
- Overnight camps are not an eligible expense under a Flexible Spending Account.

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: ______________________

Group Administrators, Ltd.

915 National Parkway, Suite F • Schaumburg, IL 60173 • (847) 519-1880 • Fax (847) 519-1979

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Group Administrators to initiate automatic deposits to my account at the financial institution named below. I also authorize Group Administrators to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Group Administrators responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Group Administrators receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Employee Information

Employee Name: _____

Social Security Number or Alternate ID:

Account Information

Name of Financial Institution: _____ ☐ Checking | ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature

Authorized Signature: _____ Date: _____

Please attach a voided check.