DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

FLEXIBLE SPENDING ACCOUNT

YOUR COMPANY NAME _____

EMPLOYEE NAME: _____

ID NUMBER: _____

ADDRESS: _____

_____

☐ Check if Name Change

☐ Check if Address Change

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

INSTRUCTIONS AND HELPFUL HINTS:

1. Please fill the claim form out in its entirety, making sure all information is entered in the sections below.
2. 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.
3. 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.
4. 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: _____