

Flexible Spending Account and Dependent Care Reimbursement Request Form

Employer Name	Work Phone	Home Phone	E-mail
Last Name	First Name	M.I.	Social Security Number
Street Address:	City:	State:	Zip:

Health Care Expenses: *Complete the information below for medical expenses incurred by your or your eligible dependents and attach a Copy of the itemized bill, receipt or EOB (explanation of benefits) from your provider or insurance carrier.*
IMPORTANT: A cancelled check or Charge Card Receipt does not satisfy the claims substantiation requirement as provided in IRS Code section 125 Q/A-7(b)(5) and will not be accepted.

Person Receiving Service	Date of Service (mm/dd/yy)	Providers Name	Amount of Expenses
Total Expenses Submitted:			

Dependent Care Expenses – *Your dependent care provider must sign this form verifying charges incurred OR you must submit a receipt from the provider with the following information.*

Note: Under dependent childcare regulations, **an expense is incurred when the service is provided, not when you pay for it.** Services must be provided during the plan year and the money withheld from your paycheck prior to being reimbursed.

If you are not submitting a receipt, complete the information below and have your dependent care provider sign. Be sure to include the providers Social Security Number or Federal Tax ID.

Name of Dependent	Provider Name	Provider SS#/Tax ID	Dates of Service (mm/dd/yy)	Amount of Expense
Total Dependent Care Expenses Submitted:				

CLAIM IS NOT BEING REIMBURSED BY INSURANCE OR EMPLOYER (click box)

To the best of my knowledge and belief, my statements in this reimbursement request form are complete and true. I certify that I or my eligible family member received the services described above on the dates indicated, that the expenses qualify as valid medical/dependent care services Under the plan. If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent under the plan. I certify that I have not been previously reimbursed for these expenses. I certify that these expenses have not been reimbursed, and are not reimburseable under the major medical plan or any other health plan established by my employer such as and HSA or HRA, or my spouse's plan. I will Assume all responsibility for any taxes or penalties arising out of any disallowed deductions. Dependent care expenses: I agree to file IRS form 2441 with my tax return and provide any taxpayer identification number required thereon.

Signature: _____

Date: _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan services provider, files a statement of claim Containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Submit Claims To: Mike Edwards Benefit Group