

Flexible Spending Account (FSA) Request for Dependent Care Reimbursement

Instructions: Please type or print the required information. Attach the appropriate receipts, invoices or other documents indicating name of the provider, provider's social security number or Federal Tax I.D. number (FEIN) and amount. Sign and return the completed form to Human Resources, Benefits Office.

1	Last	First	M.I.	SOCIAL SECURITY #
	EMPLOYEE NUMBER	Department	Email Address	

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WORK-RELATED DEPENDENT CARE REIMBURSEMENT INFORMATION

	Date of Expense From — To	Provider of Services	Provider's Social Security or Tax I.D. Number	Name of Dependent(s)	Eligible Amount*
1					\$
2					\$
3					\$
4					\$
5					\$
TOTAL					\$

* This amount must be filled in before your form will be processed by the Benefits Office.

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CERTIFICATION: Please staple invoices including date(s) of service or have dependent care provider sign here.

I provided dependent care services for the above named individual. I certify that the information provided above is correct.

Signature of Service Provider

Date

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I request payment from my FSA Dependent Care account for the expenses itemized above. I certify that (1) I have not been reimbursed under this Plan or from any other source for these expenses; (2) I have met all of the requirements for eligible dependent care expenses as described in the FSA Plan materials; (3) the services claimed above were received during the current plan year and while I was an active participant in the Plan; and (4) the total dependent care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I understand that reimbursed expenses cannot be claimed as deductions on my personal income tax return. I understand that according to IRS rules, any account balances at calendar year end will be forfeited.

**The Deadline for Submitting Claims is December 31st.
Any Remaining Funds in Your Account as of March 15th, are Forfeited.**

Employee's Signature

Date

FOR OFFICE USE ONLY

Approval: Claim approved: Yes No
 Claim not approved:- Reason _____
 Claim returned to employee on: _____

Processing: Claim entered into Computer System
 Maximum reached _____

Initials	Date	Claim Number
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