DEPENDENT CARE FSA
Reimbursement Claim Form

ACCOUNT HOLDER INFORMATION

Last Name

First Name

ID Code (last 4 digits)*

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by me for care provided by a valid dependent care provider to an eligible dependent (for children under the age of 13 or other dependents that are physically or mentally incapable of taking care of themselves) while I was a participant in the plan. I have already received these services and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the plan(s) for any such expense or for payment of all related income taxes on amounts paid from the plan(s) which relate to such expense.

Employee's Signature

Date

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
Attach a receipt from your day care provider, or include the day care provider's signature below.			**Total Dependent Care Expense Claim**	

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year of the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the plan if the service provider is your child, stepchild, or your dependent for federal income tax purposes who is under 19 years of age.

For Dependent Care Expenses, you may choose to have your provider sign and date below to certify the expenses were incurred in lieu of providing a seperate dependent care receipt.		
I certify that the dependent care expenses shown are valid.		
Dependent Care Provider Signature	Dependent Care Provider Code	Date

NOTE: At the end of the tax year you are required to provide the IRS with the provider name, address, and Tax ID# on Form 2441 in order to obtain the tax advantage of these expenses.

*Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

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by WageWorks

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Claim Form and Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. The receipt must show the date and type of service for the expense, the provider's name, and the amount of the expense. Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

Please be sure to number each attachment page (e.g., Page 2 of 3, Page 3 of 4, etc.). Your claim form is your cover page. After you fax or mail a claim with receipts, please do not follow up with a claim submitted via any other method.

Fax or mail this form with receipts to:

Fax: (877) 782-8889

Or mail to: FLEX CLAIMS GROUP
claims@takecareclaims.com
P.O. Box 14054
Lexington, KY 40512