DEPENDENT CARE REIMBURSEMENT CLAIM FORM

Please type or print all information

EMPLOYER NAME: (required for processing) _____

Social Security Number: (for security purposes, please provide at least the last 4 digits of your SSN)

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Employee Last Name:

Employee First Name:

Employee Email Address:	**Phone:**

DAY CARE EXPENSES (dependent care account)
Please provide a receipt for the services or have your daycare provider sign this form on the line below.

Documentation for each request will need to show **date of service**, **description of service** provided and **charges**, as well as the providers name and address. *IRS regulations do not allow cancelled checks, credit card receipts, or bank statements to be used as documentation of expenses.*

- Please itemize your expenses to help ensure proper processing. If you have more expenses than this form allows, please attach a separate form. If you do not itemize your expenses, we will process your claim based on the documentation received. Please avoid using highlighter on any faxes submitted, as documentation becomes illegible.
- **Active** participants may submit claims at any time during the plan year, but **must** have all claims for a given plan year submitted within 90 days after the end of the plan year. Claim submission periods for terminated participants may vary.
- Claims totaling $25 or more will be processed for reimbursement weekly, on Wednesdays and must be received no later than the end of day Friday prior to be included
- **Fax**: 330-572-8125; **Email**: admin@flexneo.com; **Mail**: 525 N. Cleveland-Massillon Rd, Ste 204, Akron, OH 44333
- For questions, please call **800-775-FLEX (3539) ext 1**

Signature of daycare provider: _____ Tax ID/ssn: _____
No payment may be made under the plan if the care provider is your dependent for federal tax purposes, or is your child or stepchild under the age of 19

Date(s) of service	Daycare provider name	Amount

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during the period while the undersigned was covered under the Company's Plan; and that the medical expenses have not been reimbursed or are not reimbursable under any other health coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes which relate to such expense.

Employee's Signature:_____ Date:_____