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# Flexible Spending Account

## DEPENDENT CARE EXPENSE RECOVERY FORM

See reverse for instructions regarding this form.

EMPLOYER (COMPANY) NAME: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ EMPLOYEE ID# \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(street) (city) (state) (zip)

If new address check here

DEPENDENT(S) NAME(S)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
_____	_____	<input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER
_____	_____	<input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER
_____	_____	<input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER

When submitting this form you must complete the information requested and attach an ITEMIZED RECEIPT, CANCELLED CHECK OR OTHER PROOF OF PAYMENT.

DATES OF SERVICE	NAME OF PROVIDER and TAX ID#	TOTAL OF AMOUNTS REQUESTED FOR REIMBURSEMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing and submitting this form you acknowledge that all requirements of Section 213 of the IRS code, as well as the plan document of your employer, have been satisfied.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR ADMINISTRATOR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

➔ EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse my employer and/or the administrator of an overpayment which is in excess of the amounts payable under the plan.

## **DEPENDENT FLEX INSTRUCTIONS:**

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Instructions for completing the Flex claim form:

- The Employer is the name of your company.
- Enter the Employee (your) name, the Employee ID Number (which is your Social Security Number), and the Employee Address.
- Check the box if this is a new address.
- List the dependent(s) name(s), date(s) of birth, and relationship(s) to the employee. If the dependent is not a child or a spouse, please specify the relationship in the Other field.
- List earliest date of dependent care through the last date being submitted. For example: (6/5/07-6/16/07). List the name of the dependent care provider and either the Tax Identification Number (TIN) of the facility or the Social Security Number (SSN) of the individual care provider. Indicate the grand total requested for reimbursement.
- **Signature is required**, as indicated by the bold arrows. Please date the form where appropriate.

This claim form and receipts may be submitted via mail, fax, or e-mail ([lindas@benetech.cc](mailto:lindas@benetech.cc)).