

Dependent Care FSA Reimbursement Form

page _____ of _____

Fax to: 888-342-5111 For faster service fax this entire sheet along with the appropriate documentation. Please do not use a cover sheet when faxing.

Employee Name: Last		First		Middle Initial		Social Security Number	
						- -	
Home Address <input type="checkbox"/> check if new address		Number/Street	Apt#	City	ST	Zip	Daytime Phone Number
							() -
Email Address <input type="checkbox"/> check if new email address				Company Name		Client Code	

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature Verification X _____ Date _____
 Required to process reimbursement

Step 1. Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. An expense is incurred when the service is provided, not when you are billed or pay for the service. Please do not submit medical or health care expenses on this form.

Complete this section if you provide receipts.

<p>Reimbursement Reminders</p> <ul style="list-style-type: none"> You must complete the boxes in this section for each expense in order for your claim to be processed properly. Copies of receipts for each expense claimed must be attached to each form. Expenses must be totaled on the page. Your receipts must contain the following: <ul style="list-style-type: none"> Date of Service Type of Service Provider of service Amount of service 	Date of Service	Provider	Type of Service	Amount of Service
	From: / /			
	To: / /			\$.
	From: / /			
	To: / /			\$.
	From: / /			
To: / /			\$.	

Complete this section if you do not provide receipts.

<p>Reimbursement Reminders</p> <ul style="list-style-type: none"> You must complete the boxes in this section in order for your claim to be processed properly. Provider must sign this form. This completed reimbursement form serves as your receipt. 	Signature of Dependent Care Provider (required if receipts are not provided)	
	X Dependent Care Provider's Name	
	SSN or Tax ID #	Amount of Service
Date of Service(include year)		
From: / / To: / /		\$.

Total Dependent Care Expenses \$

Step 2. Return this completed reimbursement form and appropriate documentation utilizing one of the following methods:
 Fax to: 1-888-342-5111. Requests received via fax will be processed the later of two business days after receipt or prior to your next scheduled reimbursement date. If you prefer, email to: FSACard@Ceridian.com, or mail to: FSA Card, P.O. Box 534321, St. Petersburg, FL 33747.

Please keep original receipts for your records as required by the IRS. Claims received via mail may require one additional day for processing. For additional information, please call our customer service center at 877-887-7739 Monday through Friday, during the hours of 8 a.m to 8 p.m. Eastern Time. Additional forms may be obtained at www.ceridian-benefits.com.

