

## Flexible Spending Account Dependent Care Expense Recovery Form

See reverse for instructions regarding this form.

Your Employer's Name	e			
Your Name:	Your ID#:			
Your HomeAddress:	(Street)	(City)	(State)	(Zip)
☐ If new address check	here			
Dependent Name(s)	Dependent(s) Date of I	of Birth Relationship To Employee		
•	rmation requested below and attach a	•	•	vo the
	eipt/statement is not available, comple rovider sign and date at the bottom of		•	e tne
Dates of Service	Name of Provider and Tax ID#	# Total Reimbursement Requested		
Provider Signature		Date		
Administrator, Files a	vingly, and With the Intent to Injure Statement of Claim Containing any ninal Act Punishable Under Law.			
<ol> <li>I agree to reimburs excess of the amou</li> <li>any amounts reimb income tax return a</li> </ol>	nts are complete and accurate; e my employer and/or the administr ints payable under the plan); and, oursed to me under this Plan will no and will not be reimbursed to me by nent Arrangement (HRA) plan or He	t be claimed as other health pla ealth Savings Ad	a deduction on my an coverage, includ	personal



## Instructions for completing this Flexible Spending Account **DEPENDENT CARE EXPENSE RECOVERY FORM**

## The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your home address.
- Check the box if this is a new address.
- List the dependent's name(s), dates(s) of birth and their relationship(s) to you (the employee). If the dependent is not a child, please specify the relationship in the "Other" field. Reimbursement requests for multiple family members may be submitted on the same form.
- List the earliest (oldest) date of dependent care through the last (most recent) date of dependent care being submitted. For example: (6/5/16-6/16/16). 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.
- The Employee's signature is required, as indicated by the bold arrow. Please date the form as well in the space provided.
- This claim form and supporting documentation (itemized receipt(s) or statement from the provider; etc.) may be submitted to Benetech via:
  - US mail -- to the address at the top of page 1; or,
  - o **Fax –** to 518.283.2384; or,
  - **Email –** to flexinfo@benetechadvantage.com