Flexible Spending Account (FSA)

Dependent Care Expense Claim Form

Employee Name: _____
(Please print.)

Employer: _____

Last 4 digits of Social Security No.: XXX – XX – _____

The undersigned Participant in the Plan requests reimbursement in the amounts shown below. Federal law stipulates that written statements, such as itemized bills and/or invoices from the service providers, must accompany all claims.

Name of Dependent: _____

Dates of Service: (mm/dd/yyyy) From _____ through _____

Name, address, and (except for certain tax exempt organizations) the taxpayer identification number of the service provider, and description of service provided.

_____

_____

_____

Claim Total $ _____

Please Read Carefully: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your wages or salary for the Plan Year or the wages or salary 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, and $500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Section 125 Plan with respect to such expenses. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no dependent care tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____

Employee's Signature (*Required*) **Date**

Submit your claim form and receipts:

Mail: Flex Claims Group, Savers Administrative Services, 615 Saint George Square Court · Suite 300 · Winston-Salem, NC 27103-1368

Fax: 336-759-3999

E-mail: flex@saversadmin.com – scan and send claim form and receipts as attachments

Please do not complete a claim form if expenses were paid with your Flex Account debit card.

If you need a Healthcare / Medical Expense Form you may download them from our Web site, www.saversadmin.com

Always remember to keep a copy of the completed claim form and supporting documents for your records.

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