Dependent Care Reimbursement Form

Please complete this form to request reimbursement for expenses incurred for eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Service at (888) 345-7990.

Participant Information

Employee Name:	**Employer Name:**
Employee ID: First Initial, Last Name & Last 4 digits of SS# (no spaces)	
E-mail Address:	**Phone #:**
Home Address:	**City, State, Zip**

Does your receipt include the following?

Provider Name and Address *Dependents Name* *Service Description* *Date of Service* *Tax ID* *Amount Billed*

**Credit card receipts and cashed checks are not a sufficient form of itemized documentation.*

Check This Box if Paid w/ Flex Card	Child's Name	Age	Service Date From	Service Date To	Service Provider	Amount

Supporting documentation for dependent care expenses is required only if provider does not sign this form.

Provider SSN# or Tax ID# _____ Signature of Provider _____

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my benefit account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Benefit Account balance to be reduced by the amount requested.

Employee Signature: _____ Date: _____

f: 844-859-7306 // claims@myflexaccount.com
8700 W. Bryn Mawr Avenue, Suite 1010S, Chicago, IL 60631
myflexaccount.com