Work-Related Dependent Care CLAIM FORM

☐ I will pick up my check - **BRING ID**

Employee Name: _____ Last 4 digits of SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ IS THIS A NEW ADDRESS? Y or N

Employer: _____ Day Time Phone #: _____

Name and age of child (children): _____

NOTE: CHILDREN ARE ELIGIBLE UP TO THEIR 13TH BIRTHDAY.

Email Address: _____

The expenses below were incurred by me on behalf of my dependent for eligible expenses under Section 125 of the Internal Revenue Code.

X_____ _____

SIGNATURE OF EMPLOYEE (required) DATE

Claim Request:

As a participant in my Employer's Work-Related Dependent Care FSA, I hereby request reimbursement for the following dates of service:

WEEK 1	__/__/__	**TO**	__/__/__	**$** _____
WEEK 2	__/__/__	**TO**	__/__/__	**$** _____
WEEK 3	__/__/__	**TO**	__/__/__	**$** _____
WEEK 4	__/__/__	**TO**	__/__/__	**$** _____
WEEK 5	__/__/__	**TO**	__/__/__	**$** _____

TOTAL AMOUNT $ _____

- Receipts from the Provider must accompany this request OR the box below must be completed.
- The individual who provided the care cannot be your spouse or your child under age 19.
- For children of divorced/legally-separated parents, only the Custodial Parent may use this benefit.

Certification from Provider:

We certify that we are providing work-related dependent care services for the Employee listed above. We also verify the charges and that we have provided service for the dates listed.

Name of Provider: _____

Federal Tax ID or Social Security #: _____

Signature of Provider: _____ Date: _____

✓ **Mail** **FlexBank Administrators, 1250 W. Dorothy Lane, Suite 107, Dayton OH 45409**
✓ **Fax** **937.299.7992 or 888.677.9373**
✓ **Email** **Claims@FlexBank.net**

Questions? Call us 888.677.8373 or visit our website www.flexbank.net.

THIS IS YOUR COVER SHEET FOR FAXED CLAIMS