FlexibleBENEFITSinc

Dependent Day Care Claim Form

Flexible Spending Account Expense Reimbursement

Please Read Your Claims Instructions Carefully

Employer Name:	
Employee Name:	
Social Security #:	
Sender's Phone #:	
Total Pages Included:	

Claims Transmittal Information

Email to: info@flexiblebenefitsinc.com

Fax to: (251) 662-1236

Please do not send separate cover sheet

Problems transmitting? Call Flexible Benefits!

251-237-1115 or 888-821-9007

Dependent Day Care Expenses

Dependent Name	Period Covered From	To	Information About Your Day Care Provider	Expense Amount
			Name:_____ Phone #: Tax I.D.:	
			Name: _____ Phone #: Tax I.D.:	
			Name: _____ Phone #: Tax I.D.:	
			Total Dependent Day Care Expense:	

I hereby certify that:

- The total amount claimed for the plan year does will not exceed the lesser of my earned income or my spouse's earned income for the plan year;
- All expenses for which reimbursement is claimed on this form were incurred during a period while I was covered under the above named Employer's Cafeteria Plan with respect to such expenses. I fully understand that I alone am responsible for the sufficiency, accuracy, and veracity of all information relating to this claim;
- I may be liable for payment of all taxes on amounts paid from the plan unless the expense for which reimbursement is claimed is a proper expense under the Plan.

I hereby authorize any service provider named above to release any information regarding expenses described above to Flexible Benefits, Inc.

_____ Employee Signature

_____ Date