

Dependent Care FSA Reimbursement Form

page _____ of _____

Fax to: 877-488-6454 For faster service fax this entire sheet along with the appropriate documentation. Please do not use a cover sheet when faxing.

Employee Name: Last	First	Middle Initial	Social Security Number - -
Home Address <input type="checkbox"/> check if new	Number/Street	Apt#	City ST Zip
			Daytime Phone Number () -
Company Name		Client Code	

By submitting this form, I attest and agree to the following: To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year (or period of coverage) for myself, my spouse and/or my dependent(s). These expenses have not previously been reimbursed under this FSA plan, nor will they be reimbursed under any other benefit plan or claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses claimed on this form and the total amount of eligible expenses on the accompanying documentation, I understand I will be reimbursed for the total amount of eligible expenses on the accompanying documentation unless I provide written instruction to reimburse a lesser amount.

Employee Signature X _____ **Date** _____

Step 1. Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. An expense is incurred when the service is provided, not when you are billed or pay for the service. Please do not submit medical or health care expenses on this form.

Receipts are provided

- You must complete the boxes in this section for each expense in order for your claim to be processed properly
- Copies of receipts for each expense claimed must be attached to each form
- Expenses must be totaled on the page
- Your receipts must contain the following information:
 - Date of Service • Provider of service
 - Type of Service • Amount of service

Date of Service	Dependent Care Provider	Type of Service	Amount of Service
From: / /			\$
To: / /			
From: / /			\$
To: / /			
From: / /			\$
To: / /			

Receipts are not provided

- You must complete the boxes in this section in order for your claim to be processed properly
- Provider must sign this form
- This completed reimbursement form serves as your receipt

Signature of Dependent Care Provider (required if receipts are not provided)	
X	
Dependent Care Provider's Name	
Date of Service (include year)	Amount of Service
From: / / To: / /	\$

Total Dependent Care Expenses \$

Step 2. Fax to 877-488-6454. Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed the later of two business days after receipt or prior to your next scheduled reimbursement date. If you prefer, mail to: Ceridian FSA Services, P.O. Box 534134, St. Petersburg, FL 33747. Claims received via mail may require one additional day for processing. Please keep original receipts as required by the IRS.

Visit www.ceridian-benefits.com 24 hours a day to obtain account information and additional reimbursement forms. For additional information, please call our customer service center at 877-799-8820 Monday through Friday, during the hours of 8 a.m. to 8 p.m. Eastern Time.