Dependent Care Flexible Spending Account (FSA) Reimbursement Form

PARTICIPANT INFORMATION			
ID Number or SSN (required)	LAST NAME	FIRST NAME	M.I.
EMPLOYER NAME		EMPLOYER ID/CLIENT CODE	

HELPFUL TIPS

- Each expense must be accompanied by supporting documentation. Your supporting documentation may consist of receipts from the provider (complete SECTION A), OR you may ask the provider to complete and sign SECTION B of this form.
- We cannot process dependent care requests before the first date of the actual service. Please do not submit your claim before the first date of service to avoid denial/delay in reimbursement.
- Make copies of your supporting documentation. Submit the copies and retain the originals for your records. **Please *do not* highlight items or staple receipts.**

STEP #1 – Complete either SECTION A or SECTION B below

SECTION A

(Use this section if you have receipts from your dependent care provider(s))

DATE OF SERVICE	PROVIDER	DEPENDENT NAME	AMOUNT
From: / /			
To:: / /			
From: / /			
To:: / /			
From: / /			
To:: / /			

SECTION B

(Use this section as your documentation by having the provider complete and sign)

DEPENDENT CARE PROVIDER'S SIGNATURE X	
Dependent Care Provider's Name	SSN or Tax ID#
Date of Service (include year) From: / / To: / /	Amount of Service $

STEP #2 – Sign the form

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 coverage period for myself and/or my legal dependent(s) under the plan. I certify that these expenses have not previously been reimbursed or will not be reimbursed under any other benefit plan, and will not be claimed as an income tax deduction.

EMPLOYEE SIGNATURE (Required) X	DATE

STEP #3 – Make copies of the supporting documentation

STEP #4 – Submit signed form(s) and copies of supporting documentation

Fax to: 866-717-3820 (Please do not use a cover sheet)

Claims with copies of documentation may also be mailed to: Ceridian FSA Services, P.O. Box 534451, St. Petersburg, FL 33747-4451
For Customer Service, please call: **877-799-8820**