DEPENDENT CARE SPENDING ACCOUNT REQUEST FOR REIMBURSEMENT

Fax Claims to: (410) 414-8432
Email: questions@careflex.com
Phone: (888) 577-2762
CareFlex Benefit Solutions
205 West Dares Beach Road
Prince Frederick, MD 20678

Employee Information

Participant Name: ______________________ Employer: ______________________

Address: ______________________ City: ____________ State: _____ Zip: ________

☐ Check if new address

Email Address: ______________________ Day Phone Number: ______________________

IMPORTANT INFORMATION…

- ➔ Failure to complete all sections of the form can result in a delay in processing your reimbursement.
- ➔ Attach an itemized receipt or invoice from the provider. If an itemized receipt is not available, the caregiver must sign and date where indicated.
- ➔ Please keep the original receipts for your records.

PLEASE DO NOT…

- ➔ Submit claims **before** services are rendered. Expenses can only be reimbursed after the date of service has passed.
- ➔ Highlight receipts or any part of the form.
- ➔ Send in credit card receipts or cancelled checks – these are **NOT** acceptable as proof of services rendered.

Dependent Care Account

Period Covered From To	Name of Dependent	Date of Birth	Provider of Services	Amount
			Name:	
			Address:	
			City: State: Zip:	
			Tax ID #:	
			Provider Phone #:	

AFFIDAVIT: Your daycare provider only needs to sign this form if you do not have supporting documentation, such as an itemized receipt. I hereby certify that I provided adult or child daycare services to the above individual(s) in accordance with the amounts and dates that are requested.

Provider's Signature:		Date:	

Period Covered From To	Name of Dependent	Date of Birth	Provider of Services	Amount
			Name:	
			Address:	
			City: State: Zip:	
			Tax ID #:	
			Provider Phone #:	

AFFIDAVIT: Your daycare provider only needs to sign this form if you do not have supporting documentation, such as an itemized receipt. I hereby certify that I provided adult or child daycare services to the above individual(s) in accordance with the amounts and dates that are requested.

Provider's Signature:		Date:	

Claim Information and Signature

PLEASE READ CAREFULLY: I certify that the expenses listed above have been incurred by me, my spouse and/or my eligible dependents during the current plan year and while I was a participant in the plan. I understand that I am responsible for the sufficiency, accuracy, and veracity of the information related to this expense. I declare that I will not deduct any of the reimbursed dependent care expenses listed above from my federal, state or local tax returns. I have not already been paid for these expenses and I have not requested and will not receive reimbursement for these expenses from any other plan. I have submitted the above information in good faith and it is correct to the best of my knowledge. I authorize CareFlex Benefit Solutions to obtain necessary information from dependent care providers, employers, and all other agencies or organizations to consider the claim for reimbursement under my Dependent Care Flexible Spending Account.

Total amount claim request: $ ______________________ Number of pages sent (do NOT fax a cover sheet): ________

Participant Signature: ______________________ Date: ______________

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CLAIM FILING INSTRUCTIONS

For specific information on the products and services that are eligible under your plan, please refer to your plan documents or contact your Plan Administrator or Employer for information.

Who can file a Claim for Reimbursement?

- Only the employee participating in the employer sponsored benefit plan can file a claim for reimbursement.
- Employees can file a claim during the current plan year and prior to the end of the run-out period for expenses incurred during the plan year.
- Terminated employees have until the end of the run-out period to submit eligible expenses incurred while employed.

I understand that:

- Only expenses for the employee and the employee's dependents (if eligible) incurred during the plan year can be claimed for reimbursement.
- Terminated employees can claim expenses for themselves and their dependents (if eligible) incurred prior to termination and within the plan year.
- Expenses must be for dependent child(ren) under age 13 and/or for my age 13 or over dependent(s) who are physically or mentally incapable of caring for themselves and includes anyone I claim on my Federal Income Tax return as a qualified IRS dependent.
- Expenses must be incurred so that my spouse and I, if married, can work, look for work or my spouse can attend school full-time.
- My household limit for dependent care reimbursement cannot exceed $5,000 per year, including my annual election, any child care subsidies that I receive, and/or amounts that my spouse has elected through another account.
- The balance in my dependent care account must be at least equal to the expenses submitted with this claim. If the balance in my account is less, these expenses will be held until the balance in my account is sufficient to pay these expenses.
- I can only be reimbursed for my dependent care expenses after the date of service has passed.

Reimbursement Procedure:

- Completed Reimbursement Request forms should be faxed, emailed or mailed to:

  205 West Dares Beach Road
  Prince Frederick, Maryland 20678
  Fax Number: (410) 414-8432
  Email: questions@careflex.com

- Claims will be paid out based on the schedule determined by the employer.

How to Request Changes in Plan Participation:

- Revocation of participation in the Plan can only occur if you have a change in family status or termination of employment. Change of family status includes birth, death, marriage, divorce, or change of employment by spouse. Contact your employer with all changes.