Benetech
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Flexible Spending Account
Dependent Care Expense Recovery Form

See reverse for instructions regarding this form.

Your Employer's Name _____

Your Name: _____ **Your ID#:** _____

Your Home Address: _____ (Street) (City) (State) (Zip)

☐ If new address check here

Dependent Name(s)	Dependent(s) Date of Birth	Relationship To Employee

When submitting this form, you must either:

1. complete the information requested below and attach an Itemized Receipt/Statement or,
2. if an itemized receipt/statement is not available, complete the information requested and have the dependent care provider sign and date at the bottom of the section immediately below.

Dates of Service	Name of Provider and Tax ID#	Total Reimbursement Requested

Provider Signature _____ **Date** _____

Any Person Who Knowingly, and With the Intent to Injure, Defraud or Deceive any Employer or Administrator, Files a Statement of Claim Containing any False, Incomplete or Misleading Information May be Guilty of a Criminal Act Punishable Under Law.

I hereby certify that:

1. **the above statements are complete and accurate;**
2. **I agree to reimburse my employer and/or the administrator for any overpayments (payments in excess of the amounts payable under the plan); and,**
3. **any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA).**

➡ **Your Signature** _____ **Date** _____

R. 07.2017

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Instructions for completing this Flexible Spending Account

DEPENDENT CARE EXPENSE RECOVERY FORM

The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your home address.
- Check the box if this is a new address.
- List the dependent's name(s), dates(s) of birth and their relationship(s) to you (the employee). If the dependent is not a child, please specify the relationship in the "Other" field. Reimbursement requests for multiple family members may be submitted on the same form.
- List the earliest (oldest) date of dependent care through the last (most recent) date of dependent care being submitted. For example: (6/5/16-6/16/16). List the name of the dependent care provider and either the Tax Identification Number (TIN) of the facility or the Social Security Number (SSN) of the individual care provider. Indicate the grand total requested for reimbursement.
- **The Employee's signature is required,** as indicated by the bold arrow. Please date the form as well in the space provided.
- This claim form and supporting documentation {itemized receipt(s) or statement from the provider; etc.} may be submitted to Benetech via:
    - **US mail --** to the address at the top of page 1; or,
    - **Fax –** to 518.283.2384; or,
    - **Email –** to flexinfo@benetechadvantage.com