FIRST BENEFIT ADMINISTRATORS

FSA
DEPENDENT CARE
REIMBURSEMENT CLAIM FORM

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where shown. In order to process your claim all required fields applicable to the claim must be completed including signatures. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

Employer Name	
Employee Name (First & Last Name)	
Social Security Number	
Daytime Phone Number	
Address: ☐ *check if address has changed*	Street: City: State: Zip:
Email	

REQUIRED: COMPLETE ALL SECTIONS

Bills or receipts showing service dates, cost and the care provider's address, Tax ID Number or Social Security Number must be submitted with claim form. Cancelled checks are NOT considered sufficient documentation.

Service Dates From	/ To	Daycare service provider Name	Provider SSN or Tax ID	Dependent Name	Birth Date	Requested Cost Per Dependent
						$
						$
						$
						$
						$
						$

I certify that I provided care as specified above

Dependent Care Provider's Signature (Necessary only if a Signed Receipt is not provided) **Date**

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.
- I have included signed copies of provider's charges, which include the dates and amount of charges.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I certify that the dependent care expenses listed above meet all the Internal Revenue Service requirements. I understand that I am r responsible for any tax reporting and other legal requirements with respect to reimbursable expenses. I also understand that dependent day care expenses for which I am reimbursed through an employee reimbursement account may not be claimed as expenses for purposes of credit against Federal income tax {IRS Form 2441). I accept sole responsibility for proper treatment of benefits paid under this Plan with respect to eligibility, income tax reporting and liability. Florida Benefit Administrators shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records. I further certify that the expenses listed above have not been previously reimbursed under this Plan or any other benefit plan.

Participant's Signature **Date**

Note: Deadline for filing current year claims for reimbursement is 90 days after the end of the plan year

MAIL OR FAX THE COMPLETED SIGNED FORM TO: **FIRST BENEFIT ADMINISTRATORS, INC**
9455 Koger Blvd. N. Suite 100, St. Petersburg, FL 33702
Phone: 727.530.4144 ◊ Fax: 727.532.9602
www.firstbenefitadmin.com