AssuredPartners
BENEFIT ADVISORS

DEPENDENT CARE FSA REIMBURSEMENT FORM

SUBMIT CLAIMS BY:
FAX: 410-771-9487
EMAIL fsa@apbenefitadvisors.com
MAIL: AP Benefit Advisors, LLC
c/o FSA Claims Processing
200 International Circle, Suite 4500
Hunt Valley, MD 21031

FOR PARTICIPANT QUESTIONS, CONTACT US...
- Customer Service Center 1-800-657-6265
- E-mail: fsa@apbenefitadvisors.com

Dependent Care Reimbursement Account Claims

Please complete this form and attach the paid receipt from your day-care provider. IRS regulations require providers to furnish their name and Tax Identification Number (or Social Security Number). **If applicable, have your day-care provider complete and sign this form below in lieu of additional receipts.** Please provide copies only. Keep all originals, including original receipts. List tuition and child care expenses only. Do not claim for field trips, supplies, food etc.

Please complete the information below:

* Employee Name	* Employer Name	* Daytime Phone		
* SSN	Email Address (optional)			
* Address	* City	* State	* Zip	❑ Change of Address

*Dates of Service (MM/DD/YY) Start	End	*Dependent Name	*Dependent Age	*Dependent Care Provider's Name	*Care Provider's Tax ID# or SSN	*Reimbursement Requested
					***Total Reimbursement**	

***REQUIRED INFORMATION**

I certify that I have incurred these eligible expenses. These expenses have not been reimbursed prior to this submission and are not reimbursable from any other source. I agree, it is my responsibility to return any duplicate reimbursement received from any other source to my account with AP Benefit Advisors, LLC. I agree that I am responsible for any and all bank, savings, or checking account charges that I incur. I agree to indemnify and hold harmless AP Benefit Advisors, LLC from any responsibility relative to my credit status. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read all printed material describing this program inclusive of the Summary Plan Description and all administrative materials defining the operation of this plan. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations and documentation. I will retain a copy of this form and all original receipts for my records.

________________________________ ________________
(Day Care Provider Signature) (Date)

________________________________ ________________
(Participant Signature) (Date)

To qualify for reimbursement from your Dependent Care Flexible Spending Account, the following is required:

1) Dependent care expenses must be incurred to enable you (and/or your spouse) to work.
2) The person providing the dependent care service must not be a child of yours under age 19 or a dependent for whom you will be entitled to a personal exemption on your federal income tax return.
3) The child(ren) being cared for must be less than 13 years old (unless physically or mentally unable to care for themselves).
4) You will be required to provide the taxpayer I.D. or Social Security number of the dependent care provider on your federal income tax return.
5) Your expense limit for the federal tax credit is reduced by the amount of reimbursed expenses through your Dependent Care Flexible Spending Account.
6) The balance in your Dependent Care Flexible Spending Account must be at least equal to the expenses submitted with this Request. If the balance in your Dependent Care Flexible Spending Account is less, these expenses will be held until the balance in your account is sufficient to pay these expenses.
7) Please note you can only be reimbursed once the end service date noted above has passed. If you wish to receive more frequent reimbursements more closely matching your deposits, we suggest using a two week service period for each receipt.