

Dependent Care FSA Reimbursement Form

page _____ of _____

Fax to: 877-488-6454 For faster service fax this entire sheet along with the appropriate documentation. Please do not use a cover sheet when faxing.

Employee Name: Last		First		Middle Initial		Social Security Number	
						- -	
Home Address <input type="checkbox"/> check if new address		Number/Street	Apt#	City	ST	Zip	Daytime Phone Number
							() -
Email Address <input type="checkbox"/> check if new email address				Company Name		Client Code	

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 plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature Verification X _____ Date _____
 Required to process reimbursement

Step 1. Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. An expense is incurred when the service is provided, not when you are billed or pay for the service. Please do not submit medical or health care expenses on this form.

Complete this section if you provide receipts.

<p>Reimbursement Reminders</p> <ul style="list-style-type: none"> You must complete the boxes in this section for each expense in order for your claim to be processed properly. Copies of receipts for each expense claimed must be attached to each form. Expenses must be totaled on the page. Your receipts must contain the following: <ul style="list-style-type: none"> Date of Service Type of Service Provider of service Amount of service 	Date of Service	Provider	Type of Service	Amount of Service
	From: / /			\$.
	To: / /			
	From: / /			\$.
	To: / /			
	From: / /			\$.
To: / /				

Complete this section if you do not provide receipts.

<p>Reimbursement Reminders</p> <ul style="list-style-type: none"> You must complete the boxes in this section in order for your claim to be processed properly. Provider must sign this form. This completed reimbursement form serves as your receipt. 	Signature of Dependent Care Provider (required if receipts are not provided)	
	X	
	Dependent Care Provider's Name	SSN or Tax ID #
Date of Service(include year)		Amount of Service
From: / / To: / /		\$.

Total Dependent Care Expenses \$

Step 2. Fax to: 877-488-6454. Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed within two days days of receipt or prior to your next scheduled reimbursement date which ever is later. If you prefer, mail to: Ceridian FSA Services, P.O. Box 534134, St. Petersburg, FL 33747. Claims received via mail may require one additional day for processing. Please keep original receipts for your records as required by the IRS.

Visit www.ceridian-benefits.com 24 hours a day to obtain account information and additional reimbursement forms. For additional information, please call our customer service center at 877-799-8820, Monday through Friday, between the hours of 8 a.m to 8 p.m. Eastern Time.

