



DEPENDENT CARE Flexible Spending
Account Request for Reimbursement

SECTION A: Employee Information (please print clearly in ALL CAPITAL letters)

Name: _____ Employee ID: _____
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: _____

Email: _____ Phone Number: _____

Address: _____

Check here if new address

SECTION B: Claim information and Signature

PLEASE READ CAREFULLY: I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I declare that I will not deduct any of the reimbursed Dependent Care expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: \$ _____ Number of pages sent (do NOT fax a cover sheet): _____

Participant Signature: _____ Date: _____

SECTION C: Dependent Care Claim details (please print clearly in ALL CAPITAL letters)

1.	Period of Dependent Care FROM DATE:	To Date:	
	Provider Name:	Age of Dependent:	
	If no receipt is available, please have caregiver sign here:	Amount:	
2.	Period of Dependent Care FROM DATE:	To Date:	
	Provider Name:	Age of Dependent:	
	If no receipt is available, please have caregiver sign here:	Amount:	
3.	Period of Dependent Care FROM DATE:	To Date:	
	Provider Name:	Age of Dependent:	
	If no receipt is available, please have caregiver sign here:	Amount:	

Total Amount for which I am requesting reimbursement: \$ _____

<p>FAX THE CLAIM TO: 888-510-4218</p> <p>or</p> <p>EMAIL TO: Claims@hfsbenefits.com</p> <p>If mailing, please keep the originals for your records. PO Box 1550 · Hunt Valley, MD · 21030-1550</p>	<p>STOP BEFORE SENDING MAKE SURE YOU ...</p> <ul style="list-style-type: none"> • Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement. • Attach proof of expense (receipt, invoice, etc.) If no receipt is available, the caregiver must sign where indicated. • Keep originals for your records. <p>STOP BEFORE SENDING MAKE SURE YOU DO NOT...</p> <ul style="list-style-type: none"> • Send in cancelled checks or credit card receipts. These are NOT acceptable. • Fax in your claim multiple times. • Send in Dependent Care Claims prior to being incurred.
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View your account online at www.hfsbenefits.com

Did you know you can **receive your payment faster** by signing up for **direct deposit!**
Sign up online today!