Flexible Spending Account (FSA)
Dependent Care Easy Reimbursement Request

benesyst

Account Holder Information
(Please print in ALL CAPITAL letters) (i.e. A B C D E)

Participant's Daytime Phone (with Area Code first)

Participant's Social Security Number *Failure to provide your SSN may delay processing

FSADC

Participant's First Name

Participant's Last Name

Participant's Employer Name

Participant's Email Address *Automatic Opt in to receive information via email from Benesyst. Your address is kept 100% confidential.

Participant's Dependent's Name

Participant's Statement and Signature PLEASE READ CAREFULLY:

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's Flexible Spending Account Plan with respect to such expenses and that the expenses have not been reimbursed by any other Flex Account. I, the undersigned, certify that these expenses were incurred by a federally eligible dependent and are expenses permitted under federal law. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I certify that the expenses are for the care of my children while my spouse and I (if applicable) are working and the expenses do not include: enrichment classes (i.e. after school, summer, etc.), babysitter who is a dependent, educational expenses, school tuition (including kindergarten), workshops, language lessons, overnight camp, diaper fee, meals, snacks, beverages, activity/supply fees, field trips, lessons (i.e. music, voice, sports, education, etc.) or transportation expenses.

X _____ Participant's Signature

_____ Date

Daycare Provider Information

Name:

REQUIRED: Daycare Provider's Tax ID or Social Security Number

IF DAYCARE PROVIDER COMPLETES REIMBURSEMENT SECTION AND SIGNS BELOW, SEPARATE BILLING OR RECEIPTS ARE NOT NEEDED

I, the undersigned, certify that I have provided daycare for the participant's dependents as listed above for the periods indicated. The participant is responsible for the cost of these services, which have already have been provided. I further certify that I am not a child of the participant unless I am also (a) not a dependent of the participant and (b) over age 19.

X _____ Daycare Providers Signature

_____ Date

Expense Information

Dates of Care (Month-Day-Year) (i.e. 01-01-09—01-31-09)		Dependent Date of Birth (Month-Day-Year) (i.e. 01-01-09)	Amount Due for Each Period of Care	
From	To		Dollars	Cents
— —	— —	— —	.	
— —	— —	See Date of Birth Above (one dependent per claim form)	.	
— —	— —	See Date of Birth Above (one dependent per claim form)	.	
— —	— —	See Date of Birth Above (one dependent per claim form)	.	
Please Fax Your Claim To (800) 310-8279 Or Mail to: Benesyst Claims, 800 Washington Ave. N 8th floor, Minneapolis, MN 55401		Total Expense →	.	

Documentation Page

Place Reimbursement Form on Top and Fax to (800) 310-8279.

Please tape smaller items to the center of this page. Use a new page for each item. If your item is the size of this page, please fax as an individual page. Please make copies of this page as needed.
