

Flexible Spending Account (FSA)

Dependent Care Reimbursement Form



SECTION (I) PERSONAL INFORMATION

Last Name	First Name	Email address (if available)
Member ID	Employer Name	Work Phone Number

SECTION (II) DEPENDENT CARE EXPENSE INFORMATION

Item No.	Date of Expense		Provider of Services	Provider's Social Security of Tax Identification Number	Name of Your Dependent(s)	Eligible Amount of Expenses
	From	Through				
1						\$
2						\$
3						\$
4						\$
5						\$
6						\$
Total of Eligible Expenses						\$

SECTION (III) EXPENSE CERTIFICATION

In order to certify the the expenses above, please do either #1 or #2 below. You do not have to do both #1 and #2.

- 1) Please staple invoices including date(s) of service, OR
- 2) Have the dependent Care provider verify the information with a signature below.

<p>_____</p> <p>Signature of Service Provider</p> <p><i>I provided dependent care services for the above named individual. I certify that the information provided above is correct.</i></p>	<p>____/____/____</p> <p>Date of signature</p>
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SECTION (IV) EMPLOYEE AUTHORIZATION AND SIGNATURE

By my signature below, I request payment from my Dependent Care Flexible Spending account for the itemized expenses listed above or attached to this form. By my signature below, I certify the following:

- 1) I have not been reimbursed under this FSA Plan or from any other source for these expenses;
- 2) I have met all of the requirements for eligible dependent care expenses as described in the FSA Plan Document and other FSA materials
- 3) The services claimed above were received during the current plan year and while I was an active participant in the Plan;
- 4) The total dependent care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lessor of my or my spouse's earned income for the year. I understand that reimbursed expenses cannot be claimed as deductions on my personal income tax return. I understand that according to IRS rules, any account balances at calendar year end will be forfeited.

APPLICANT SIGNATURE	DATE
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For processing, please remit this form and any attachments to:

via fax <i>(local in Charlotte, NC)</i>	via email <i>(scan and email as attachment)</i>	via US Mail
1-704-845-5629	claims@integrahealth.com	Integra BMS Attention: Claims P.O. Box 1178 - Matthews, NC 28106