Dependent Care FSA Reimbursement Form

Employee Name: Last	First	Middle Initial	Last 5 Digits of Social Security Number

Home Address ☐ check if new address Number/Street	Apt#	City	ST	Zip	Daytime Phone Number

Email Address ☐ check if new email address	Company Name
@	

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 o 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.

Reimbursement Reminders:	Date of Service	Claimant	Type of Service	Amount of Service

• You must complete the boxes in this section for each expense in order for your claim to be processed properly.
• Your receipts must contain the following:
  • Date of Service
  • Type of Service
  • Provider of Service
  • Amount of Service
• Copies of receipts for each expense claimed must be attached to the form.
• Expenses must be totaled on each page.
	From: / /			

	To: / /			$.
	From: / /			
	To: / /			$.
	From: / /			
	To: / /			$.

Complete this section if you do not provide receipts.

Reimbursement Reminders:	Signature of Dependent Care Provider (required if receipts are not provided)	
• 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	X	
	Dependent Care Provider's Name	SSN or Tax ID #
	Date of Service (include year) From: / / To: / /	**Amount of Service** $.

Total Dependent Care Expenses $ _____

Step 2 Fax to (866) 469-4720. Return this completed reimbursement form and appropriate documentation. Requests received via fax will be processed within three business days after receipt. If you prefer, email to membercare@mypeak1.com.

Visit www.mypeak1.com 24 hours a day to obtain account information and additional reimbursement forms.