NEW YORK STATE FLEX SPENDING ACCOUNT

A STATE EMPLOYEE BENEFIT THAT PUTS MONEY IN YOUR POCKET

DEPENDENT CARE ADVANTAGE FORM
REIMBURSEMENT REQUEST FORM

A

NAME		SOCIAL SECURITY NUMBER	
ADDRESS	**CITY**	**STATE**	**ZIP**

B

LIST THE NAMES AND ADDRESSES OF THE PROVIDER(S)[1] Or SERVICE FOR WHICH YOU ARE APPLYING FOR REIMBURSEMENT	PROVIDER SS# OR FEDERAL TAX ID NUMBER	DATE(S) INCURRED[2] MONTH/DAY/YEAR	REIMBURSEMENT AMOUNT
1. NAME / ADDRESS			
NAME & RELATIONSHIP OF PERSON RECEIVING DAY CARE:			
I HAVE RECEIVED PAYMENT FOR CARE PROVIDED. SIGNED:			DATE:
2. NAME / ADDRESS			
NAME & RELATIONSHIP OF PERSON RECEIVING DAY CARE:			
I HAVE RECEIVED PAYMENT FOR CARE PROVIDED. SIGNED:			DATE:
3. NAME / ADDRESS			
NAME & RELATIONSHIP OF PERSON RECEIVING DAY CARE:			
I HAVE RECEIVED PAYMENT FOR CARE PROVIDED. SIGNED:			DATE:

[1] Provider means day care center, special school, or individual providing day care service.

[2] If the service was provided for more than one day, show the beginning date and the ending date of the service.

DATE INCURRED IS THE DATE SERVICE IS PROVIDED, NOT PAID.

(USE ADDITIONAL PAPER IF MORE SPACE IS NEEDED)

C

THE ABOVE IS A TRUE AND ACCURATE STATEMENT OF UNREIMBURSED DEPENDENT CARE EXPENSES INCURRED BY ME OR MY ELIGIBLE DEPENDENTS ON THE DATE(S) INDICATED. I UNDERSTAND THAT I AM RESPONSIBLE FOR MISREPRESENTATIONS REGARDING REQUESTS FOR REIMBURSEMENT. THE SIGNATURE OF THE CARE PROVIDER(S) REPRESENTS RECEIPT FOR ALL CLAIMED EXPENSES. I UNDERSTAND THAT EXPENSES REIMBURSED HEREIN CANNOT BE CLAIMED ON MY INCOME TAX RETURN. ALL DEPENDENT CARE EXPENSES WERE INCURRED TO ENABLE ME AND MY SPOUSE, IF APPLICABLE, TO WORK OR LOOK FOR WORK (OR, MY SPOUSE IS A FULL-TIME STUDENT OR INCAPABLE OF SELF CARE).

SIGNATURE _____ DATE _____

IMPORTANT INSTRUCTIONS AND INFORMATION!
Please Print or Type

1. This Reimbursement Request form must be signed by you and your care provider(s), or you may attach separate receipts from your service providers that list the name, address and tax ID number (or SS#) of the provider. Requests will not be processed without this information.
2. Reimbursement can only be made for those expenses resulting from services that occur during the Plan Year.
3. Any unused year-end balance in your DCAAccount may not be carried over to the next plan year. The funds will be forefeited and returned to NYS, as your employer.
4. The deadline to incur expenses is the last day of the month of the plan year. However, NYS allows a 90-day grace period after the end of the Plan Year, during which time you may submit reimbursement requests for services incurred during the previous Plan Year. Reimbursement Requests postmarked later than March 31st will not be processed.
5. If dates of service for which you are seeking reimbursement begin in one Plan Year and end in the next Plan Year, a Reimbursement Request form for each year is required.
6. Be sure to sign and date **SECTION C**.
7. Call 1-800-342-8017 for Customer Service, Fringe Benefits Management Company, Plan Administrator for the Dependent Care Advantage Account Program.
8. Mail or fax to:

FRINGE BENEFITS MANAGEMENT COMPANY
P.O. BOX 1820, TALLAHASSEE, FL 32302

or

TRIM YOUR DEPENDENT CARE EXPENSES—FAX FREE!
1-800-743-3271

FBMC USE ONLY: DATE RECEIVED: _____ AUTHORIZATION # _____ INITIAL _____

11/29/05