FSA*Direct* NO-WAIT DEPENDENT CARE REIMBURSEMENT

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

GENERAL INFORMATION

Group: Plan ID:

Partic. ID# If this is a new address check here ☐

Name Last First

Address

City State Zip -

Phone ( ) - - E-Mail

Important: You **must** attach receipts from your dependent care provider or have your provider sign in the appropriate block next to the detail item. **Do not** attach checks or credit card slips as the IRS does not recognize these as valid receipts for this program.

Fax the completed form to 800-726-9982 or 704-335-0818 in the Charlotte area.
Or mail the completed form to: Claims Processing• P.O. Box 31397• Charlotte, NC 28231-1397

Claim Submission Deadline:

You have until the above day after the end of the plan year to submit claims for the previous

REIMBURSEMENT REQUEST DETAIL

Please complete one section for each included receipt and total at the bottom. Use additional forms as needed.

Service Date From: Service Date To: Dependent Cost

Service Provider

Tax ID#:

Provider Signature (Required If Receipt Not Attached)

Service Date From: Service Date To: Dependent Cost

Service Provider

Tax ID#:

Provider Signature (Required If Receipt Not Attached)

Service Date From: Service Date To: Dependent Cost

Service Provider

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Service Date From: Service Date To: Dependent Cost

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Tax ID#:

Provider Signature (Required If Receipt Not Attached)

Service Date From: Service Date To: Dependent Cost

Service Provider

Tax ID#:

Provider Signature (Required If Receipt Not Attached) Total

REIMBURSEMENT AUTHORIZATION

I understand that dependent care expenses reimbursed under this plan can not be claimed as a deduction on my personal income tax return. I acknowledge that neither the group nor Flores & Associates, LLC(1) is independently verifying that the dependent care providers I select comply with state and local laws applicable to them, (2) has any responsibility for or obligations relating to the dependent care services rendered by any dependent care provider or any of its employees or representatives and (3) is making any commitment or guarantee that any money which is deducted from my pay (salary) is excludable from my gross income for federal, state or local income tax purposes. I also understand that it is my obligation to determine whether the amount deducted from my pay is excludable from my gross income and to notify the group if I have reason to believe any such payment is not so excludable. I agree to hold the group and Flores & Associates, LLC harmless from any and all liability and costs which either or both may incur as a result of, or in connection with, the provisions of dependent care service to me or on my behalf by any dependent care provider.

Participant Signature (Void if not signed) Date Signed