



Flexible Spending Account Dependent Care Request for Reimbursement

Employee Name: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ IS THIS A NEW ADDRESS? Y or N

Employer: _____ Day Time Phone #: _____

Name(s) & Ages of Child(ren): _____

NOTE: CHILDREN ARE ELIGIBLE UP TO THEIR 13TH BIRTHDAY.

Email Address: _____

The expenses below were incurred by me on behalf of my dependent for eligible items under Section 125 of the Internal Revenue Code.

SIGNATURE OF EMPLOYEE (required)

DATE

Claim Request:

As a participant in my Employer's Flexible Spending Account Plan, I hereby request the FlexBank Flexible Spending Account Plan Services to reimburse me for:

WEEK 1	____/____/____	TO	____/____/____	\$	_____
WEEK 2	____/____/____	TO	____/____/____	\$	_____
WEEK 3	____/____/____	TO	____/____/____	\$	_____
WEEK 4	____/____/____	TO	____/____/____	\$	_____
WEEK 5	____/____/____	TO	____/____/____	\$	_____
TOTAL AMOUNT				\$	_____

Receipts from the Provider must accompany this request OR the box below must be completed

Certification from Provider:

We certify that we are providing Dependent Care Services for the Employee listed above. We also verify that we have provided service for the dates listed.

Name of Provider: _____

Federal Tax ID or Social Security #: _____

Signature of Provider: _____ Date: _____

FlexBank, Inc.

1250 West Dorothy Lane, Suite 107

Phone: (937) 299-5515 ~ Claims Fax Number: (937) 299-7992

Hours: 9 A.M. – 5 P.M. M-F

(NO COVER PAGE REQUIRED WHEN FAXING)