DEPENDENT CARE FSA
How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at **www.FSAFEDS.gov** to submit your claim electronically with uploaded documentation.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Toll-free Fax:** 866-643-2245, **US Mail:** FSAFEDS Program – Claims, P .O. Box 14127, Lexington, KY 40512-4127

If you have questions: Visit the FSAFEDS website at **www.FSAFEDS.gov** or contact an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (372-3337), TTY: 866-353-8058, Monday through Friday from 9 a.m. until 9 p.m., Eastern Time.

Who is a qualifying dependent? A dependent is defined as someone who spends at least 8 hours a day in your home and is one of the following:

- A tax dependent child under the age of 13 for whom you have custody more than half of the year.
- A dependent that is physically or mentally incapable of self-care regardless of age.

Eligible Expense: For a list of eligible expenses specific to your plan, go to **www.FSAFEDS.gov** and select "Eligible Expense". The only expenses considered eligible are those that are incurred while you or your spouse are working, looking for work, or attending school full time.

Examples of eligible expenses include:

- Before and after-school care
- Child care at a day/child care center, nursery school or by a private sitter
- Day (summer or holiday) camps, including registration fees
- Late pick-up fees
- Adult care center or private care giver of a physically or mentally incapable dependent

Examples of ineligible expenses include:

- Overnight camps
- Non-work related day care
- Late payment fees
- Education/Tuition expense for kindergarten or higher-grade

Documentation Requirements: Proof of services from a third party provider of service: The provider of service cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your tax returns.

- **Provider of service documentation that includes:** Provider Name, Service Dates (not payment date), Dependent Name, Type of Service and Out-of-Pocket Costs

OR

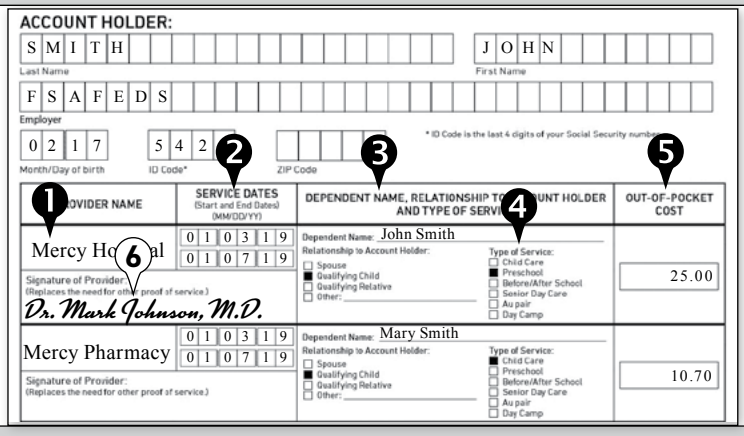
- Your provider may sign the form confirming the date of services, charges and other service in lieu of providing separate documentation.

Instructions to fill out this form:

- Complete ALL account holder information.
- Use your documentation to complete each section of the form, including the following:
  1. **Provider Name**
  2. **Service Dates**
  3. **Dependent Name and Relationship to account holder**
  4. **Type of Service**
  5. **Out-of-Pocket Cost**

Optional:

- **Provider Signature can replace need for separate documentation or other proof of service**



Claim Submission Tips

- Ensure that the documentation is legible.
- Do not Highlight your documentation; it can cause documentation to be illegible.
- Cancelled or copies of checks and credit card receipts are not acceptable forms of documentation: they do not include the required information (listed above) to approve your expense.
- All documentation must be submitted in English (foreign receipts should be translated to English and US dollars)
- Cover page is not recommended when faxing claim
- Original documentation should be kept for your record, send a photocopy of your documentation if submitting via US Mail.
- Submit only claims you wish to be reimbursed from your own account.

Claim Status Tips

- Please allow up to 5 business days from receipt of your claim for processing.
- You will be notified of the status of your claim based on your choice within your www.FSAFEDS.gov "Profile" preferences.
- To update your "Profile" preferences, log in to your account at www.FSAFEDS.gov and select "Profile" in the top right corner of the screen.

DEPENDENT CARE FSA

Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at **www.FSAFEDS.gov** to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Toll-free Fax:** 866-643-2245, **US Mail: FSAFEDS Program – Claims, P.O. Box 14127, Lexington, KY 40512-4127**
- **Claim processing time:** Claims will be processed within 5 business days after receipt of the form. You may check the status of your claim by logging in to your account at **www.FSAFEDS.gov**.
- **If you have questions:** Visit the FSAFEDS website at **www.FSAFEDS.gov** or contact an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (372-3337), TTY: 866-353-8058, Monday through Friday from 9 a.m. until 9 p.m., Eastern Time.

ACCOUNT HOLDER:

Last Name

First Name

Employer

ID Code*

Month/Day of birth

ZIP Code

* ID Code is the last 4 digits of your Social Security number.

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ____ Relationship to Account Holder: ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ Type of Service: ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Day Camp	
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ____ Relationship to Account Holder: ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ Type of Service: ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Day Camp	
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ____ Relationship to Account Holder: ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ Type of Service: ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Day Camp	
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ____ Relationship to Account Holder: ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: ____ Type of Service: ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Day Camp	

More expenses? Please complete another form.

CLAIM FORM TOTAL: 0

CERTIFICATION AND AUTHORIZATION: I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the User Agreement at www.FSAFEDS.gov (available upon registration; enter username and password or click on New to the Site? link).