FLEXFACTS
a company of grant benefit solutions

Please send this form along with all applicable receipts to:

1200 River Avenue, Suite 10E, Lakewood, NJ 08701
Fax: 877-747-8564
E-Mail: Claims@flexfacts.com

Dependent Care Account Claim Form

Personal Information

Full Name: _____ _____ _____
Last *First* *M.I.*

Employer: _____

Social Security Number: _____

Phone: _____ E-mail: _____

If your address has changed please list the new address below.

New Address: _____

City, State, Zip _____

Please note: All fields below must be filled out in order for claim to be approved.

Claim Information

Name of Dependent: _____ Dependent Date of Birth: _____

Provider Name: _____ Provider Tax ID: _____

Service Start Date*: _____ Service End Date*: _____

Claim Amount: $_____

Provider Signature (if you are unable to obtain a receipt): _____

Name of Dependent: _____ Dependent Date of Birth: _____

Provider Name: _____ Provider Tax ID: _____

Service Start Date: _____ Service End Date: _____

Claim Amount: $_____

Provider Signature (if you are unable to obtain a receipt): _____

Employee Certification

- By signing this form, I agree to have my DCA account reduced by the amount requested.
- This claim for reimbursement is only for eligible expenses incurred by eligible plan participants during the plan year. Please refer to your SPD and Plan Document for information on eligible expenses.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- I understand I am required to file Form 2441 at the end of each tax year, to obtain the tax advantage for dependent care expenses.
- *I understand and agree that I am obligated to inform Flexfacts in writing if the amount charged for the dependent care services change, the service is terminated, or if there is any reason the expenses are not incurred.

Employee Signature: _____ Date: _____