

DEPENDENT CARE Flexible Spending

Account Request for Reimbursement

SECTION A: Employee Information (please print clearly in ALL CAPITAL letters)

Na	me: (FIRST NAME LAST NAME)		Employee ID:(This may be your SSN or employer assigned number;		
				(This hilly be your solver employer assigned in	
Em	nail:		Phone Number:		
Ad	dress:Check here if new address				
SECTION	ON B: Claim information and	Signature			
participa		listed below have been incurred by me, my spouse and, all expenses below are eligible under the plan. I declare to tax returns.			
Tot	tal amount of this claim requested: \$	Number of pag	es sent (do NOT fax	a cover sheet):	
≥ Pa	rticipant Signature:			Date:	
		details (please print clearly in ALL CAPITAL letters)			
1.	Period of Dependent Care FROM DATE:	To Date:			
	Provider Name:	Age	of Dependent:		
	If no receipt is available, please have caregiver sign here:		Amount:		
2.	Period of Dependent Care FROM DATE:	To Date:			
	Provider Name:	Age	of Dependent:		
	If no receipt is available, please have caregiver sign here:		Amount:		
3.	Period of Dependent Care FROM DATE:	To Date:			
	Provider Name:	Age of Dependent:			
	If no receipt is available, please have caregiver sign here:		Amount:		

Total Amount for which I am requesting reimbursement: \$_____

FAX THE CLAIM TO: 888-510-4218

or

EMAIL TO: Claims@hfsbenefits.com

If mailing, please keep the originals for your records. PO Box 1550 · Hunt Valley, MD · 21030-1550

STOP BEFORE SENDING MAKE SURE YOU ...

- Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement.
- Attach proof of expense (receipt, invoice, etc.) If no receipt is available, the caregiver must sign where indicated.
- Keep originals for your records.

STOP BEFORE SENDING MAKE SURE YOU DO NOT...

- Send in cancelled checks or credit card receipts. These are NOT acceptable.
- Fax in your claim multiple times.
- Send in Dependent Care Claims prior to being incurred.