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Flexible Spending Account DEPENDENT CARE EXPENSE RECOVERY FORM

See reverse side for instructions regarding completion of this form.

YOUR EMPLOYER _____

YOUR NAME _____ YOUR ID# _____

YOUR HOME ADDRESS _____ (Street) _____ (City) _____ (State) _____ (Zip)

If this is a new address, check here

DEPENDENT(S) NAME(S)	DATE(S) OF BIRTH	RELATIONSHIP TO EMPLOYEE
		<input type="checkbox"/> CHILD <i>If "Other," please specify:</i>
		<input type="checkbox"/> OTHER
		<input type="checkbox"/> CHILD <i>If "Other," please specify:</i>
		<input type="checkbox"/> OTHER
		<input type="checkbox"/> CHILD <i>If "Other," please specify:</i>
		<input type="checkbox"/> OTHER

When submitting this form you must complete the information requested and attach an **ITEMIZED RECEIPT AND CANCELLED CHECK OR OTHER PROOF OF PAYMENT.**

DATES OF SERVICE	NAME OF PROVIDER AND TAX ID#	TOTAL REIMBURSEMENT REQUESTED

By signing and submitting this form you acknowledge that all requirements of Section 213(d) of the IRS code, as well as the plan document of your employer, have been satisfied.

ANY PERSON WHO KNOWINGLY, AND WITH THE INTENT TO INJURE, DEFRAUD OR DECEIVE ANY EMPLOYER OR ADMINISTRATOR, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

I hereby certify that any amounts reimbursed to me under this Plan:

1. will not be claimed as a deduction on my personal income tax return; and,
2. will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse my employer and/or the administrator of an overpayment which is in excess of the amounts payable under the plan.

 YOUR SIGNATURE _____ DATE _____

**Instructions for completing this Flexible Spending Account
DEPENDENT CARE EXPENSE RECOVERY FORM**

The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your home address.
- Check the box if this is a new address.
- List the dependent's name(s), date(s) of birth and relationship(s) to you (the employee). If the dependent is not a child or a spouse, please specify the relationship in the "Other" field. Reimbursement requests for multiple family members may be submitted on the same form.
- List the earliest (oldest) date of dependent care through the last (most recent) date of dependent care being submitted. For example: (6/5/07-6/16/07). List the name of the dependent care provider and either the Tax Identification Number (TIN) of the facility or the Social Security Number (SSN) of the individual care provider. Indicate the grand total requested for reimbursement.
- **The Employee's signature is required**, as indicated by the bold arrow. Please date the form as well in the space provided.
- This claim form and supporting documentation {receipt(s); cancelled checks; etc.} may be submitted to Benetech via:
 - **US mail** -- to the address at the top of page 1; or,
 - **Fax** -- to 518.283.2384*; or,
 - **Email** -- to flexinfo@benetech.cc

*** NOTE: as of January 2011, this is a new fax number. Please use this number for all your Flex claims submissions.**