



P.O. Box 1392
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Cafeteria Plan - Dependent Care Claim

For Accuflex Office Use:

Date Received:	
By:	

Part 1 – Employee Information

Employer Name:	City	State
Employee Name:	Date of Birth:	Social Security Number:
Employee Mailing Street Address:	City:	State & Zip

Part II– Dependent Care Reimbursement Request (attach receipts)

Dates of Service		Dependent's Full Name & Description of Care	Age	Total Amount Requested
Begin Date	End Date			
Total Amount Requested				
Provider Tax ID or SS #:		Tax Exempt? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Provider Name:		Provider Address:		

Part III – Employee Certification for Reimbursement

I hereby certify that:

- The above information is correct; and
- I have not received reimbursement previously for these expense from my Flexible Spending Account(s) or any other plan; and
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than \$5,000.

I understand that:

- Reimbursement for dependent care expenses are reimbursed up to the amount of my plan-year-to-date contributions received by Accuflex.
- Reimbursement is not a guarantee that this payment is tax-free.
- Reimbursed dependent care expenses cannot be use as a dependent care credit on my personal income tax return, that these reimbursements will reduce, and may eliminate, my ability to claim a dependent care credit on my personal income tax return.
- Expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account(s).

I hereby authorize Accuflex Services, Inc., or its representative, to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacists, employers, and all other organizations, including other insurers, to consider the claim for reimbursement under my Flexible Spending Account(s).

Employee Signature: _____ **Date:** _____