Submitting your Dependent Care Flexible Spending Account Claims

Review these instructions before submitting your claims!

Go green! Submit claims online!
Visit:

FAX

1-866-643-2219

MAIL

ADP Spending Accounts, P.O. Box 34700, Louisville. KY 40232

IMPORTANT NOTE: Dependent Care FSA Expenses are generally considered eligible when incurred for expenses related to care of a dependent less than 13 years of age. Exceptions may be allowed if documentation verifies that dependent is incapable of self-care. The care must be provided in order to allow the parent(s) or legal guardian(s) to work or seek employment on a full-time basis. Eligible dependents are also defined in your Summary Plan Description.

SECTION 1: EMPLOYEE INFORMATION

Your details (Employee Name, Employer Name, Address, Phone number and Participant ID) are pre-populated in this section for your convenience.

For any updates to your pre-populated information shown here, please contact your Employer or HR representative.

1 – Start date of service as seen on the receipt

2 – End date of service as seen on the receipt

Helpful tips to fill out the claim form:

SECTION 1: EMPLOYEE INFORMATION

Employee Name JOHN SMITH (First, Last) — Employer Name ABC COMPANY

Address 111, WALNUT

City NEWYORK — State NY — Zip 12345 — Phone 987654321

Participant ID : 1 2 3 4 5 6 7 8 9

YOUR DETAILS ARE PRE-POPULATED IN THIS SECTION

SECTION 2: YOUR EXPENSE INFORMATION

Important Note: Dependent Care FSA Expenses are generally considered eligible when incurred for expenses related to care of a dependent under 13 years of age. The care must be provided in order to allow the parent(s) or legal guardian(s) to work or seek employment on a full-time basis. Exceptions may be allowed if documentation verifies that dependent is incapable of self-care.

Start Date of Service MMDDYY	Start Date of Service MMDDYY	Dependent Name	Provider's Names	Amount Dollars.Cents
1	2	3	4	5

Optional: If this is a re-submission, please enter your Reference ID here: 6

SECTION 3: DEPENDENT CARE SERVICE PROVIDER CERTIFICATION (***Required only if receipt is not provided***)

I certify that the services for the above noted service period(s) and cost(s) have been incurred by the claimant and that these expenses have not previously been certified.

Service Provider Signature ______ 7 ______ Date ______ MMDDYY

SECTION 4: CERTIFICATION

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me for my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement from any other source. I understand that where an expense is reimbursed and is subsequently deemed ineligible, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Copy of bills, statements, receipts or other proofs of ex[...]hed.

Employee Signature ______ 8 ______ Date ______ MMDDYY ZDZCZRZ

3 – Dependent's Name for whom the service was provided

4 – Name of the provider from whom the service was received

5 – Amount

6 – This can be a document ID or any other reference ID given by ADP

7 – Signature & date of the dependent care service provider (Mandatory if receipts are unavailable)

8 – Claim Form received without signed certification cannot be processed

- Submit expenses after the services have been incurred
- Preferably TYPE your claim information in this Form and PRINT
- For faster reimbursements, enroll in FREE Direct Deposit online
- Claim line for each dependent must be filled separately
- You may refer to the online eligible expense guide before submitting claims
- Include all supporting documents/receipts for all the expenses associated with your claim **(or)** have the Dependent Care Service Provider sign Section 3 of this form

- Refrain from highlighting receipts or any part of the form
- Don't use red ink, if filling out this form by hand
- Do not staple copies of your receipts to the claim form
- Don't include this instruction sheet along with your fax/mail
- Copy of Cancelled check or Credit Card receipt are not accepted as valid receipts per IRS

For Questions Call Customer Service :

Dependent Care FSA Claim Form

FAX TO: 1-866-643-2219 TOLL FREE

DYCYFY

Go Paperless & avoid filling out this form. Submit claims online for fast and secure processing! Visit:

This information is privileged and confidential. If you are not the intended recipient, notify the sender immediately and destroy this document and all supporting attachment. Further use or disclosure is strictly prohibited.

TIPS TO REMEMBER WHEN SUBMITTING DEPENDENT CARE FSA EXPENSES:

1. Preferably TYPE your claim information in this Form and PRINT. Don't use red ink, if filling out this form by hand
2. Do NOT submit claims for future Start and End dates of Service. Do NOT use a highlighter on claim form/receipt(s)
3. Do NOT mail original receipts. Credit Card receipts & Cancelled checks are NOT acceptable
4. Claim form MUST be signed & dated. Submit claim with itemized receipt(s) **or** have the Dependent Care Service Provider sign Section 3 of this form

SECTION 1: EMPLOYEE INFORMATION

Employee Name

First Last

Employer Name

Address

City State Zip Phone

Participant ID :

Note: For any updates to your pre-populated contact information above; please contact your Employer or HR representative.

SECTION 2: YOUR EXPENSE INFORMATION

Important Note: Dependent Care FSA Expenses are generally considered eligible when incurred for expenses related to care of a dependent under 13 years of age. Exceptions may be allowed if documentation verifies that dependent is incapable of self-care. The care must be provided in order to allow the parent(s) or legal guardian(s) to work or seek employment on a full-time basis.

Start Date of Service	End Date of Service	Dependent Name	Provider's Names	Amount
MMDDYY	MMDDYY			Dollars . Cents
				$
				$
				$
				$
Optional: If this is a re-submission, please enter your Reference ID here:			**Total Expenses**	$

FAX: 1-866-643-2219 Toll Free

MAIL: ADP Spending Accounts
P.O. Box 34700
Louisville, KY 40232

CUSTOMER SERVICE:

For Admin Use Only

Control Number:

Participant ID:

SECTION 3: DEPENDENT CARE SERVICE PROVIDER CERTIFICATION (***Required only if receipt is not provided***)

I certify that the services for the above noted service period(s) and cost(s) have been incurred by the claimant and that these expenses have not previously been certified.

Service Provider Signature Date

SECTION 4: CERTIFICATION

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me for my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement from any other source. I understand that where an expense is reimbursed and is subsequently deemed ineligible, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Copy of bills, statements, receipts or other proofs of expenses are attached.

Employee Signature Date

MMDDYY

DYCYFY