DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

ACCOUNT RULES AND CLAIM FILING INSTRUCTIONS

RULES

- You can only submit a claim if you are participating in the Cafeteria Plan.
- You can only be reimbursed for eligible expenses incurred during the coverage period in which your contributions are made.
- You can submit a claim at any time during the plan year, and for a specified period after the plan year, as described in the Summary Plan Description. If you terminate employment, the services must have been incurred prior to your date of coverage termination.
- IRS rules stipulate that any money left in your account(s) after all reimbursements for the plan year have been processed cannot be carried forward or returned. Money in one account cannot be used for expenses incurred in another account. *For example, any unused funds in the Medical FSA cannot be used to reimburse dependent care expenses.*
- You cannot submit a claim for a service period that begins in one plan year and ends in the next plan year. You must file two reimbursement claims, one for each plan year covering the period during that plan year.
- You cannot receive payment from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expenses.
- If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.

INSTRUCTIONS

- Complete ALL information on the form for each amount claimed for reimbursement. Incomplete forms cannot be processed (this includes for lack of SSN).
- Attached copies of required documentation to the claim (See Required Documentation below for information).
- Sign and date the claim.
- Make a photocopy of the claim for your records.
- Submit the claim and required documentation via fax, email, mail or through our website. Please limit faxed claims to 9 pages or less.

REQUIRED DOCUMENTATION

- You must submit an itemized statement which includes the provider's name, address and Social Security Number or Tax Identification Number (TIN).
- Please specify the date(s) of service that are being claimed and the amount you are requesting for reimbursement.
- Under the IRS guidelines, some expenses are not considered eligible as a deductible expense. *This includes fees such as registration, deposits, transportation, meals, school tuition and optional educational classes.*

P.O. Box 520, Euless, TX 76039 Phone: (817) 731-6258
Fax: (817) 731-9029 Email: claims@abybenefits.com Website: www.abybenefits.com

P.O. Box 520, Euless, TX 76039 Phone: (972) 788-2686
Fax: (972) 788-3240 Email: claims@allamericanbenefits.com Website: www.allamericanbenefits.com

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

NAME_____ EMPLOYER_____ SSN _____-_____-_____

HOME (MAILING) ADDRESS_____ CITY_____ STATE_____ ZIP_____

☐ *check here if your address has recently changed*

EMAIL ADDRESS _____@_____ DAY PHONE (_____) _____-_____ (optional)

				Is your proof of expense & payment attached?			Yes No
SUMMARY OF EXPENSES					**Dates of Service**		**Payment**
Name of Individual Receiving Services	Age & Grade	Relationship to Employee	Service Provider Name & Address	Provider Tax ID or SSN (Signature of Provider is Required on Receipt)	From MM/DD/YY	To MM/DD/YY	Employee's Responsibility (Reimbursement Amount)
Claims must be filled out completely and received by 12pm prior to the processing day in order to obtain reimbursement during the next processing cycle. Please note your check will be mailed or direct deposit uploaded on the processing day, however please allow 3-5 business days to receive payment.						**TOTAL**	

I (above named Participant) understand and agree that:

- These expenses are not reimbursable from any other health plan, insurance or other source, and will not be used to claim any federal income tax deduction or credit.
- The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code Section 213 and are allowed under Prop. Treas. Reg. 1.125-2;
- If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent under the plan as defined in Code Section 152;
- By submitting this information (via fax, e-mail, or any other media), I am responsible for any inappropriate use or disclosure that may occur due to incorrect or inaccurate transmissions;
- I authorize the Plan and its service provider, their respective agents, employees, sub-contractors and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan Administration purposes such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation;
- I authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud;
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above; and
- This authorization does not in any way limit any right that ER/PSP, their respective agents, employees, sub-contractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

EMPLOYEE SIGNATURE: _____ DATE: _____