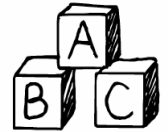




Dependent Care

Flexible Spending Account Claim Form



PERSONAL INFORMATION:

Last Name: First Name:

ID Number: Phone Number:

Name of Employer:

REIMBURSEMENT INFORMATION:

	Service Dates:		Provider Name:	Provider Signature*:	Reimbursement Requested:
	From:	To:			
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

TOTAL:

* If the provider signature is not included on this claim form, I have enclosed a **COPY** of supporting documentation per my plan specification.

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I certify that the dependent care expenses listed above meet all the Internal Revenue Service requirements. I understand that I am responsible for any tax reporting and other legal requirements with respect to reimbursable expenses. I also understand that dependent day care expenses for which I am reimbursed through an employee reimbursement account may not be claimed as expenses for purposes of credit against Federal income tax (IRS form 2441). I accept sole responsibility for proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability. Fiserv Health shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records. I understand that submitting false claim information could lead to termination of employment, potential prosecution, and possible implications with the Internal Revenue Service (IRS).

EMPLOYEE SIGNATURE: _____ **DATE:** _____

FAX TO: 877-390-4782 (toll-free) or 715-841-7049
SEND TO: Fiserv Health • MS 6230, Claim Services • P.O. Box 8022 • Wausau, WI • 54402-8022
INQUIRIES: www.fiservhealthservices.com or 1-800-826-9781 ext. 2189

The deadline for filing current year claims for reimbursement is 90 days after the end of the plan year unless otherwise specified in your Plan Document.