

# Flexible Spending Account (FSA) *Daycare Easy Reimbursement Request*

**NO FAX COVER SHEET IS NECESSARY IF FAXING**

<b>To: Benesyst FSA Department</b>	Date:	<b>REQUIRED: Your Social Security Number</b>			
Attn:		□ □ □ - □ □ - □ □ □ □			
From (Last Name, First Name):	Your Fax Number: ( ) -				
Your Daytime Phone Number: ( ) -	Total Pages:	Employer AND Division, If Applicable:	Participant's Daytime E-mail Address:		

**Participant's Statement and Signature**

**PLEASE READ CAREFULLY:**

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's Flexible Spending Account Plan with respect to such expenses and that the expenses have not been reimbursed by any other Flex Account. I, the undersigned, certify that these expenses were incurred by me or a federally recognized dependent and are expenses eligible under federal law. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. **I certify that the expenses are for the care of my children while my spouse and I (if applicable) are working and the expenses do not include: enrichment classes (i.e. after school, summer, etc.), babysitter who is a dependent, educational expense (i.e. tuition, workshop, lesson, etc.), overnight camp, diaper fee, meals, snacks, beverages, activity/supply fees, field trips, lessons (i.e. music, voice, sports, education, etc.) or transportation expenses.**

- IMPORTANT: Use TWO forms if expenses are from different plan years.
- Requests for the current benefit plan year must be received by Benesyst before the run-out period ends.
- Please keep your originals and either fax or mail 8½" x 11" copies of documentation for the expenses included on this form together with this form. Benesyst is unable to return documents submitted. If the form is not completed in its entirety it may be returned to you to complete and it will delay your reimbursement.
- Please Note: an eligible receipt must include ALL of the following: Provider's Name, Date of Service, Description of Service and Cost of Service. Your claim will be processed and appear on the Benesyst website (www.benesyst.net) two (2) business days after receipt.

**X**

\_\_\_\_\_

**Plan Participant's Signature**

\_\_\_\_\_

**Date**

**Dependent Daycare Reimbursement Section** *(Bills or receipts must be attached and individually listed below unless provider signs below).*

All fields are required. Failure to complete each item will slow down the processing of your claim.

Dates of Care From To	Service Provider Information	Name of Dependents	Age	Amount of Expense
		Care for children aged newborn through 12 yrs old only		
				\$
				\$
				\$
	Name: _____			\$
				\$
	Address: _____			\$
				\$
	REQUIRED: _____			\$
	Service Provider's Tax ID or Social Security Number			\$
				\$
				\$
<b>TOTAL DEPENDENT DAYCARE EXPENSE REQUEST (this page only, use as many forms as needed):</b>				<b>\$</b>

**IF DAYCARE PROVIDER COMPLETES REIMBURSEMENT SECTION AND SIGNS BELOW, SEPARATE BILLING OR RECEIPTS ARE NOT NEEDED**

I, the undersigned, certify that I have provided daycare for the participant's dependents as listed above for the periods indicated. The participant is responsible for the cost of these services, which have already have been provided. I further certify that I am not a child of the participant unless I am also (a) not a dependent of the participant and (b) over age 19.

**X**

\_\_\_\_\_

**Dependent Daycare Provider's Signature**

\_\_\_\_\_

**Date**

*MAKE PHOTOCOPIES OR OBTAIN ADDITIONAL FORMS THROUGH BENEFITS ONLINE AT [HTTP://BENEFITS.NORTHGRUM.COM](http://benefits.northgrum.com)*

**Mail or Fax (not both) all requests to:**

Benesyst, Inc./ 800 Washington Avenue North, 8th Floor, Minneapolis, MN 55401/ Fax:612-338-7969 or 800-310-8279/ Ph: 612-338-7131 or 800-670-7131