Send to: Health Cost Solutions
P.O. Box 1439 Hendersonville, TN 37077
Fax: (615) 333-4196
Email: flexadmin@hcsbenefits.com

FSA

Flexible Spending Account

DEPENDENT DAY CARE EXPENSES

Reimbursement Request

Section 1: EMPLOYEE INFORMATION

Name ____ Social Security No. ____________________
(last) (first) (middle initial)

Location ____ Daytime Phone No. ____________________

Home Address ____
(Street) (City) (State) (Zip Code)

Marital Status ________________

Documentation must be provided with the following and will not be returned. Copies should be made prior to submission.

- Name of care provider
- Date that care was received (mm/dd/yy)
- Amount of the expense and any adjustments
- Name of dependent who received care

Section 2: (Please place each expense on a separate line)

a. Expense Code	**b.** Dates of Service From	To	**c.** Name of Care Provider	**d.** SS# or Tax ID # of Provider	**e.** Amount Requested	**f.** Total Charges	**g.** Dependent who received care	**h.** Relationship	**i.** Birthdate

I authorize the expenses listed above to be reimbursed through my Dependent Day Care Flexible Spending Account. I certify that, to the best of my knowledge, the dependent care expenses I am submitting meet the requirements of employment-related day care expenses. If married I further certify that these expenses, together with any other dependent day care expenses already reimbursed through my Dependent Day Care Flexible Spending Account, do not exceed the lesser of my earned income or the earned income of my spouse.

EMPLOYEE SIGNATURE ____ **DATE** ____________________