

**Send to: Health Cost Solutions
P.O. Box 1439
Hendersonville, TN 37077
Fax: (615) 333-4196**

FSA
Flexible Spending Account
**DEPENDENT DAY CARE
EXPENSES
Reimbursement Request**

Section 1: EMPLOYEE INFORMATION

Name _____ <small>(last) (first) (middle initial)</small>	Social Security No. _____
Location _____	Daytime Phone No. _____
Home Address _____ <small>(Street) (City) (State) (Zip Code)</small>	
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 _____