Dependent Day Care Claim Form

Flexible Spending Account Expense Reimbursement

Please Read Your Claims Instructions Carefully

Employer Name:	**Claims Fax Transmittal Information**
Employee Name:	Fax to: 251-666-0101 (Local Mobile);
Social Security #:	or
Sender's Phone #:	1-800-FAXFLEX (1-800-329-3539)
Total Pages Included:	**Please do not send separate cover sheet**
	Problems transmitting? Call FlexComp
	251-666-1999 or 800-340-8077

Dependent Day Care Expenses

Dependent Name	Period Covered From	To	Information About Your Day Care Provider	Expense Amount
			Name: _____ Phone #: Tax I.D.:	
			Name: _____ Phone #: Tax I.D.:	
			Name: _____ Phone #: Tax I.D.:	
			Total Dependent Day Care Expense:	

I hereby certify that:

- The total amount claimed for the plan year does will not exceed the lesser of my earned income or my spouse's earned income for the plan year;
- All expenses for which reimbursement is claimed on this form were incurred during a period while I was covered under the above named Employer's Cafeteria Plan with respect to such expenses, and reimbursement will not be sought from other sources. I fully understand that I alone am responsible for the sufficiency, accuracy, and veracity of all information relating to this claim;
- I may be liable for payment of all taxes on amounts paid from the plan unless the expense for which reimbursement is claimed is a proper expense under the Plan.

I hereby authorize any service provider named above to release any information regarding expenses described above to FlexComp Administration Services, Inc.

_____ _____

Employee Signature Date

phone: 251.666.1999
800.340.8077

p.o. box 91566
mobile, al 36691-1566

fax: 251.666.0101
800.329.3539