TOTAL ACCESS FSA
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Your Employer Name: ____

Employee Name: ____
(Please print or type)

Social Security Number: ______ – _____ – ________

Address: ____

____

City: ____________________ **State:** __________ **Zip Code:** __________

Daytime Phone Number: (________) _______ - __________
(Area code)

E-mail: ____

Use this form to submit claims for reimbursement from your Dependent Care FSA. If you are submitting claims for other FSA plans at the same time, you may use the multi-plan FSA Claim Form for your convenience.

DEPENDENT CARE EXPENSES

Dates of Expense	Caregiver	Amount Paid	Amount Requested
	$		$
	$		$
	$		$
	$		$
	$	**Total:**	**$**

Supporting Information: For dependent care expenses, attach copies of receipts that indicate name of dependent, name and address of payee, amount paid and period for which payment was made and, except for certain tax-exempt organizations, the **Taxpayer Identification/Social Security** number of the provider of services.

PLEASE SIGN THE FOLLOWING STATEMENT:
I certify that I (or my dependents) have incurred the expenses for which reimbursement is claimed. I declare that these expenses have not been, and will not be, reimbursed under any other program and will not be claimed as an income tax deduction.

Employee Signature:____**Date**:________________

Instructions:
Mail or fax this form and supporting documents to:

Benergy OS
Attn: FSA
353 S. Potomac Street
Waynesboro, PA 17268
(fax): 516-414-5122

If you have any questions, contact Benergy OS by e-mail at FSAclaims@benergyos.com or by phone at 800-768-4909. Subsequent claims can be submitted with the claim form you receive with your reimbursement check. Thank you for allowing us to be of service.