



FLEXIBLE SPENDING CLAIM FORM

Employee Name _____ **Member ID** _____
Place of Employment _____ **Group Number** _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

To submit Dependent Care Account claim form you must:

1. Complete this form.
2. Submit an itemized bill or receipt from the provider of service which contains the following information:
 - Person or institution providing day care
 - Amount charged for service
 - Dates of service
 - Name of person/child receiving service
3. Retain copy for your records.

DAY CARE EXPENSES

Name of Dependent	Age	Relationship to Employee
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that these expenses have been incurred to care for my eligible dependent(s) under the age of 13 years and have been previously reimbursed and are not eligible for reimbursement through any other plan. I certify that either I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement under any other plan. Furthermore, I declare that I will not deduct these expenses on my own or anyone else's individual Federal Income Tax Return.

Employee's Signature _____ Date _____

**SUBMIT ALL CLAIMS TO:
AULTCARE FLEXIBLE SPENDING ACCOUNT
PO BOX 6910 CANTON OH 44706
Fax 330-363-2096**