

# Dependent Care Recurring Expense Form



COMPANY INFORMATION (PLEASE PRINT)	
Company Name	Division (if applicable)

EMPLOYEE INFORMATION (PLEASE PRINT)		
First Name	Home Phone ( ) -	
Last Name	Work Phone ( ) -	
SSN	Email Address (For Notification of Claims, Payments & Account Status)	
Street Address (Check if New Address <input type="checkbox"/> )		Apt#
City	State	ZIP

Please provide the following information for eligible dependents:

NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
		/ /
		/ /
		/ /

RECURRING REIMBURSEMENT REQUEST (PLEASE PRINT)
Please indicate your qualifying expenses below. <b>DO NOT include expenses reimbursed by any other source.</b> Attach copies of bills/receipts OR your Dependent Care Provider's Signature. Documentation must include dates of service, description of service, provider's name and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

DEPENDENT CARE (Daycare) – FLEXIBLE SPENDING ACCOUNT (FSA)
It is hereby acknowledged by (Dependent Care Provider information below):
PROVIDER'S TAX ID (or SSN)      PROVIDER'S BUSINESS or NAME

That I (the Dependent Care Provider) will receive the following payment... From the above named for Dependent Care Services.	<b>TOTAL Dependent Care Reimbursement Request</b>  \$ _____ <b>(REQUIRED)</b>
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DATE RANGE OF SERVICES	From      /      /      through      /      /
Dependent Care Provider's Signature:	Date      /      /

DEPENDENT CARE RECURRING EXPENSE REQUEST (Requires above section completed.)
Automatically process your Dependent Care Expenses for reimbursement. This means you would <u>not</u> need to complete another Claim Reimbursement Request Form for your Dependent Care in the current plan year <u>assuming you do not change providers during the plan year.</u>
<input checked="" type="checkbox"/> <b>YES</b> - Please make this a Recurring Dependent Care Claim - I have provided either copies of bills/receipts OR my Provider's Signature above.

CLAIM CERTIFICATION	
I certify these expenses for which reimbursement is requested on my Flexible Spending Account have been incurred by me, my spouse or my eligible dependent(s) & are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return. <b>Note: Incomplete forms cannot be processed and will be returned to the participant.</b>	
Signature	Date      /      /

SEND THIS FORM & A COPY OF RECEIPTS TO CHARD SNYDER (DO NOT SEND ORIGINAL RECEIPTS)	
Please submit this form with your required documentation to Chard Snyder via one of the three methods listed to the right...	<input checked="" type="checkbox"/> <b>Fax to:</b> Local (513) 459-9947 / Toll-Free (888) 245-8452 ( <b>Please DO NOT include a Fax Cover Page</b> ) <input checked="" type="checkbox"/> <b>Mail to:</b> 3510 Irwin Simpson Rd, Mason, OH 45040 <input checked="" type="checkbox"/> <b>Email to:</b> <a href="mailto:askpenny@chard-snyder.com">askpenny@chard-snyder.com</a>