PLEASE MAIL/FAX TO: **FCF Benefits & Administration**
2494 E. Kays Creek Dr.
Layton, UT 84040
Fax – (801) 683-3595
E-mail: claims@fcfinc.com

NOTE: **For claims questions, call claims dept. 801- 939-4900 X 206**

Dear Employee:
Following is a claim form to receive reimbursement for your dependent care expenses for your Flexible Spending Account(s). Please note that each item should be listed separately and the receipt attached for each reimbursable item. **Each receipt must show the original date of service and the type of service provided.** Please keep a copy of each receipt for your records.

DEPENDENT CARE EXPENSE
(BABYSITTING EXPENSES/ELDER DAYCARE)

Instructions: Fill in the necessary information below for the dependent day care expenses incurred by you or by your eligible dependents for which you request payment. A receipt showing date of expense must accompany each expense item. Please keep a copy of each receipt for your records.

COVERED PERIOD		Person Who Received the Care	Age at time of service	Care Provider Name	Amount
Starting Date	Ending Date				

Total Dependent Care Claim $_____

****THIS INFORMATION IS REQUIRED FOR REIMBURSEMENT.** **Complete for each daycare provider (PLEASE PRINT)**

NAME: _____ NAME:_____

ADDRESS:_____ ADDRESS:_____

_____ _____

TAX ID #: _____ TAX ID #: _____

_____ _____
Daycare Provider's Signature **Daycare Provider's Signature**

TO THE BEST OF MY KNOWLEDGE AND BELIEF, MY STATEMENTS IN THIS REIMBURSEMENT REQUEST FORM ARE COMPLETE AND TRUE. I AM CLAIMING REIMBURSEMENT ONLY FOR ELIGIBLE EXPENSES INCURRED DURING THE APPLICABLE PLAN YEAR. I CERTIFY THAT THESE EXPENSES HAVE NOT BEEN PREVIOUSLY REIMBURSED UNDER THIS OR ANY OTHER BENEFIT PLAN AND WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.

_____ _____ _____
SIGNATURE OF EMPLOYEE Date Employer Name

_____ (_____)_____
Please Print Name Day Time Phone Number

E-mail Address:_____