

Dependent "Day Care" Recurring Expense Form **FAX: 1-888-207-2310**

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Please use this form to make a claim for recurring dependent "day care" expenses.

1) Employee/Participant Information		2) Dependent Information			
Employer/Plan Sponsor		Dependent's Name		Relationship To Employee	Date of Birth
Your Name		Dependent's Name		Relationship To Employee	Date of Birth
Address		Dependent's Name		Relationship To Employee	Date of Birth
City, State and Zip Code		3) Dependent Care Provider Information			
Your Social Security Number		Dependent Care Provider's Name			
Your Email Address		Dependent Care Provider's Tax ID or SSN			
Your Phone Number		The costs for the day care services are (choose only one):			
		WEEKLY	BI-WEEKLY	SEMI-MONTHLY	MONTHLY
		\$	\$	\$	\$
		These rates are effective (1st payment date):			
		Beginning Date		Ending Date	
		Dependent "Day Care" Provider: Please read and sign below:			
		I hereby certify that the expenses detailed above are accurate.			
		Dependent Care Provider Sign Here			Date Signed
		Please use separate forms if you have more than one day care provider and/or more than one payment schedule.			
		When your completed recurring claim is received, it will be setup for automatic reimbursement for a maximum of 12 months or the remainder of the plan year in which the "beginning date" shown above, whichever is less. For example, if the plan year is calendar and this form is received in February, the claim will be setup for 11 months, beginning in February and ending in December.			
		Please let us know immediately if your day care situation changes during the year. If the rates or care provider changes during the year, you will need to send in a new recurring expense claim. You will need to submit a new recurring claim for each plan year.			
EMPLOYEE/PARTICIPANT - PLEASE READ AND SIGN BELOW					
<p>I hereby certify, understand and agree that: I make regular payments to the Dependent Care Provider as detailed in this form and I request recurring reimbursement for those expenses; I will immediately notify FlexToday if this arrangement changes and I do not have these expenses (vacations, illness, rate or provider changes, etc.); The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under any other benefit plan for these expenses; These expenses were incurred during the coverage period by either me or my eligible dependents; I assume the responsibility to maintain substantiating documents for all claims; I understand that this claim form will not be returned to me and I am responsible for retaining my own copy; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); It is my responsibility to obtain and report to the IRS the Identification Number of any and all dependent care providers to whom I have paid for services which were submitted for reimbursement under this Plan; I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadlines, and; I may receive notifications by email instead of mail and I understand that I must notify FlexToday in writing to rescind this authorization to send notifications by email.</p>					
Employee/Participant Sign Here		Date Signed			

FlexToday, Inc. • 191 W Shaw Ave Ste 101 • Fresno, CA 93704 • Ph: 559-432-6800 or 800-995-5373
 Claims Fax 1-888-207-2310 • Alternate Fax 1-469-398-0423 • **Secure Claims Portal Link**

You can send claims to us by fax, mail or electronically (scanned) at the Secure Claims Portal. **We do not accept claims by email.** The "digital signature" feature is only available if you have Adobe Acrobat (6+); the digital/electronic signature is not available with Adobe Reader. Claims sent to the Secure Claim Portal should be in Adobe ".pdf" format. If your claim requires multiple Adobe files, the files must be named similarly and numbered (001, 002, etc.). **PLEASE identify yourself in the "Add A Message" box.** Unidentified files and files sent in any format other than Adobe ".pdf" may be unacknowledged and will not be treated as an actual claim submission. Files or links sent to the Portal in executable formats (.exe, .zip, .eml, .com, .net, .html, vbs, etc.) will be deleted without opening or notice.