

DEPENDENT DAY CARE REIMBURSEMENT FORM / ACKNOWLEDGMENT FORM

THIS FORM CANNOT BE USED FOR MEDICAL EXPENSE REIMBURSEMENT REQUESTS

Name of Employer		Daytime Phone (with area code)
Name of Employee (Last, First, M.I.)		Social Security #
Address	City & State	Zip Code
Is this a New Address? Yes No	Email Address (print clearly):	

* You will receive notification by e-mail when your claim is received and another when a payment is sent. You will also receive e-mail notification of direct deposits. Please be sure your e-mail address is legible.*

It is hereby acknowledged by _____ ("Dependent Day Care Provider") that it is in compliance with any and all applicable federal, state and local regulations governing dependent day care centers. The Dependent Day Care Provider further acknowledges that it has billed or received \$ _____ from _____ (Employee's Name/ "Participant") for dependent day care services rendered for the period of _____ through _____ for the following eligible individuals:

Name of dependent	Age
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_____	_____
_____	_____

Please provide the following required information for Dependent Day Care Reimbursement:

_____	_____
Name of Dependent Day Care Center or Individual Provider	Tax ID number of Dependent Day Care Center or Social Security Number of Individual Provider
_____	_____
Address of Dependent Day Care Center or Individual Provider	Signature of Dependent Care Center Representative or Individual Provider
	Date: _____

I authorize the above expenses to be reimbursed from my Dependent Day Care Account. To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my dependent as defined in Code Section 152 has received the services described above on the dates indicated and that the expenses are valid dependent care expenses under the Plan; that the reimbursement requested will not exceed the applicable earned income limit; and that the expense reimbursement requested meets all other rules and regulations of Code Sections 129 and 21. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit and that the expense has not been reimbursed, nor will be sought, under insurance or any other plan. I understand that the day care provider's name, address and tax ID must be included on my annual tax return by completing Schedule 2 of Form 1040A or Form 2441.

_____	_____
Signature of Employee	Date Signed

Who is a Qualifying Dependent for Dependent Day Care Plans?

- **Your qualifying child**, who is either 1) under the age of 13 and who has the same principal place of abode as the taxpayer for more than half of the taxable year, **or** 2) is physically or mentally incapable of self-care, who has the same principal place of abode as the taxpayer for more than half of the taxable year, and who routinely spends at least 8 hours per day in the taxpayer's home (age restriction does **not** apply).
- **Your qualifying relative**, who is physically or mentally incapable of self-care, who has the same principal place of abode as the taxpayer for more than half of the taxable year, who routinely spends at least 8 hours per day in the taxpayer's home, and who does not have gross income exceeding \$3,200 per year.
- **Your spouse**, who is physically or mentally incapable of self-care, who has the same principal place of abode as the taxpayer for more than half of the taxable year, and who routinely spends at least 8 hours per day in the taxpayer's home.

Visit www.afadvantage.com for more details on qualifying dependents and to access additional claim forms. You may also sign up for an account activation code to view your flexible spending account information. Visit our site for details!

Mailing Address: American Fidelity Assurance, Flex Account Administration, P. O. Box 25510, Oklahoma City, OK 73125

Fax Number: (800) 543-3539 You may call after 24 hours for confirmation of receipt of a fax. Average processing time is 5 to 7 working days from receipt of a completed voucher. American Fidelity will not be responsible for faxes not received.

FlexConnection® Interactive Phone Response Number: (800) 325-0654

SECTION 125 FLEXIBLE BENEFIT PLAN EXPENSE REIMBURSEMENT VOUCHER

Name of Employer		Daytime Phone (with area code)
Name of Employee (Last, First, M.I.)		Social Security #
Address	City & State	Zip Code
Is this a New Address? Yes No	*Email Address (print clearly):	

*** You will receive notification by e-mail when your claim is received and another when a payment is sent. You will also receive e-mail notification of direct deposits. Please be sure your e-mail address is legible.***

Date of Service	Description of Expense	Family Member for Whom Expense Was Incurred	Amount of Expense	
			Medical Expense	Dependent Day Care
TOTAL				

UNREIMBURSED MEDICAL (URM) EXPENSE GUIDELINES: With the expense voucher, you will need to submit a professional bill or receipt that includes the following: 1) Service provider's name; 2) Type of service rendered; 3) Charge for service; and 4) Original date of service. Note: the date of service, NOT the date of payment, must fall within the dates of the Section 125 plan year (or grace period, if applicable) for which you are enrolled. When submitting a claim for orthodontia, you must provide a copy of the service contract with your first reimbursement request. Receipts for service should include a detailed description of the service. Acceptable documentation of an expense includes an insurance company's explanation of benefits or a pharmacy statement with an Rx number and name of prescription. Unacceptable documentation includes cancelled checks, credit card receipts or a statement or bill that shows a balance forward, previous balance or payment due.

DEPENDENT DAY CARE (DDC) EXPENSE GUIDELINES: You must submit a completed Dependent Care Acknowledgment Form with the expense voucher for reimbursement.

*****INCOMPLETE VOUCHER OR ACKNOWLEDGMENT FORMS MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM*****

I authorize the above expense(s) to be reimbursed from my medical expense and/or dependent care reimbursement account(s), whichever applies. To the best of my knowledge, my statements on this form are true and complete. I certify all of the following: Either I, my Spouse, or my Dependent has received the services described above on the dates indicated and the expenses qualify as valid medical care expenses under Code Section 213(d) . If I am a participant of a Health Savings Account and am also covered under a Limited Purpose medical expense account, the above expenses qualify as being services that are eligible under the account. These expenses have not previously been reimbursed under the medical expense or dependent care reimbursement account or any other health plan and I will not seek reimbursement for them under my medical insurance or any other health plan. I understand that expenses for cosmetic purposes, toiletries or for general good health do not constitute an eligible expense. I understand that expenses reimbursed may not be used to claim any federal income tax deductions or credit. I also understand that I may be asked to provide further details about some expenses, such as a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me.

Date Signed

Signature of Employee

<p>Mailing Address: American Fidelity Assurance, Flex Account Administration, P. O. Box 25510, Oklahoma City, OK 73125</p> <p>Fax Number: (800) 543-3539 You may call after 24 hours for confirmation of receipt of a fax. American Fidelity will not be responsible for faxes not received. Average processing time is 5 to 7 working days from receipt of a completed voucher. Additional Forms and Account Information are available on our website at: www.afadvantage.com</p> <p>FlexConnection® Interactive Phone Response Number: (800) 325-0654</p>
