

DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

COMPANY NAME: _____

EMPLOYEE NAME: _____

ID NUMBER: — —

PHONE NUMBER: _____

E-MAIL ADDRESS: _____

SEND CLAIMS TO:

Group Administrators, Ltd.
Attention: FSA Administration
 953 American Lane, Suite 100
 Schaumburg, Illinois 60173

Email: fsa@groupadministrators.com
 Fax: (847) 519-1979

Telephone: (800) 323-1683

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT OF POCKET COST
		Dependent Name: _____ Relationship to Account Holder: Type of Service: <input type="checkbox"/> Qualifying Child <input type="checkbox"/> Child Care <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Pre-School <input type="checkbox"/> Spouse <input type="checkbox"/> Before/After School <input type="checkbox"/> Other: _____ <input type="checkbox"/> Senior Day Care <input type="checkbox"/> <input type="checkbox"/> Au Pair <input type="checkbox"/> <input type="checkbox"/> Summer Day Camp	\$ _____
Signature of Provider: (Replaces the need for other proof of service.)			
		Dependent Name: _____ Relationship to Account Holder: Type of Service: <input type="checkbox"/> Qualifying Child <input type="checkbox"/> Child Care <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Pre-School <input type="checkbox"/> Spouse <input type="checkbox"/> Before/After School <input type="checkbox"/> Other: _____ <input type="checkbox"/> Senior Day Care <input type="checkbox"/> <input type="checkbox"/> Au Pair <input type="checkbox"/> <input type="checkbox"/> Summer Day Camp	\$ _____
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Signature of Provider: (Replaces the need for other proof of service.)			

Qualified Dependents Include:

- ♦ Dependents under the age of 13 (if care is provided outside your home, dependent must spend at least eight (8) hours per day in your home).
- ♦ Incapacitated parent, spouse & child of any age living with you and dependent on you for at least 50% of support.

Qualified Expenses include:

- ♦ Those enabling you and your spouse, if applicable, to work.
- ♦ Care already received (expenses cannot be reimbursed until after care has actually been provided).
- ♦ A licensed daycare facility in one complying with all state laws and providing care for more than six (6) individuals other than those residing in the facility.
- ♦ No educational expenses qualify as dependent care, including Kindergarten.
- ♦ Overnight camps are not an eligible expense under a Flexible Spending Account.

EMPLOYEE CERTIFICATIONS:

I hereby certify that my request for reimbursement applies to claims for legitimate expenses incurred on the date noted. I will not request reimbursement for these expenses from any other plan, and I will not claim these expenses on my income tax return to the amount that I have available in my account.

SIGNATURE: _____

DATE: _____



Group Administrators, Ltd.

915 National Parkway, Suite F • Schaumburg, IL 60173 • (847) 519-1880 • Fax (847) 519-1979

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Group Administrators to initiate automatic deposits to my account at the financial institution named below. I also authorize Group Administrators to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Group Administrators responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Group Administrators receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Employee Information

Employee Name: _____
Social Security Number or
Alternate ID: _____

Account Information

Name of Financial Institution: _____ Checking | Savings

Routing Number:

Account Number:

Signature

Authorized Signature: _____ Date: _____

Please attach a voided check.