Reimbursement Services
P.O. Box 534385
St. Petersburg FL 33747-4385

Employee Name _____
Mailing Address _____
City, State Zip _____

Participant ID _____ Company Name _____ Client ID _____

FAX TO: 866-863-6598 (Reimbursement Account Administration) **Page _____ of _____**

For faster service, fax this entire sheet, completed and signed, along with the appropriate documentation. Please complete all applicable spaces.

Mail your claim forms to: P.O. BOX 534385, St. Petersburg FL 33747-4385

To obtain a claim form, go to www.benefitenroll.com <http://www.benefitenroll.com>.

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable coverage period for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount requested for reimbursement and the total amount of receipts attached, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature: _____ Date: _____

Dependent Care Flexible Spending Account

Service Date	Expense Type	Service Provider	Patient Name	Amount
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
			Total Submitted	**$**

Around the clock service at www.benefitenroll.com < http://www.benefitenroll.com>. Access your account data, obtain forms, and quickly find answers to your questions. Customer service professionals are available to assist you by calling 800-586-5120 from 8AM to 8PM ET Monday through Friday.

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