# 2017 Dependent Day Care Flexible Spending Account Reimbursement Request

*FLEX_DC*

ASSURANT

*Required Field

## Instructions

- Complete sections A, B, and C entirely. Provider Name, Address and Tax ID or SSN are required for reimbursement.
- Services must be rendered prior to flexible spending reimbursement.
- Attach receipts or bills from the dependent day care provider showing dates of attendance, provider name, dependent name, and amount charged. The provider may sign and date the Provider Signature line in Section D in lieu of attaching receipts except for camps.
- Day Camp charges should be primarily for custodial, not for educational or entertainment purposes. Camp must be during a standard workday (no overnight camps). Receipt must show days and hours of attendance.
- Please allow two weeks for reimbursement.

Submit the completed form along with the appropriate documents to:

**Secured Fax number** 651.361.4036

**NOTE:** To ensure a timely reimbursement, please submit via fax. **Do not use a cover sheet**.

**Mail to** the address on the bottom of this form if unable to send by fax.

## A. Employee Information

| SOCIAL SECURITY NO. (LAST 4 DIGITS)* | LAST NAME* | FIRST NAME* | MI* |
|---|---|---|---|
| | | | |

## B. Dependent Day Care Expenses

| Dates of Attendance From* | To* | Name of Dependent(s)* | Age* | Provider Name* Provider Street Address*,City*,State*,ZipCode* Provider Tax ID or SSN* | Amount to be Reimbursed* |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |

Total $ _____

## C. Employee Certification

I request reimbursement of above expenses from my Assurant Dependent Day Care Flexible Spending Account. By signing below, I certify and warrant to my employer that all of the following are true:

- The information above is correct and complete.
- I incurred the above expenses; they have not been and will not be paid or reimbursed by any other source.
- Each dependent above is an "Eligible Dependent" as defined in the Dependent Day Care Spending Account portion of the Health and Welfare Summary Plan Description, available at http://MyAssurantBenefits.com.
- The services enabled me to work *and* for my spouse (if any) to work or attend school full-time. (Note: spouse need not meet this requirement if mentally/physically incapable of self-care.) For example, if I work only part-time, the above services were provided during my scheduled work hours and not when I am off work.
- The services were provided by a licensed entity or a person whom I can not claim as a dependent on my tax return.
- The services were provided as a Day Care service (*e.g.*, not kindergarten tuition, summer school, or overnight camp).

I understand the terms and conditions of the Assurant Dependent Day Care Flexible Spending Account, and that I am benefiting from before-tax pay deductions. I agree that in the event my certification above is incorrect, I can be held personally responsible for all financial, legal, tax and other consequences for myself and my employer. I will maintain copies of all documentation for my records. My employer is authorized to perform an ACH reversal or stop payment on any funds that are reimbursed in error.

Employee signature* _____ Date* _____

## D. Provider Certification in lieu of receipts (camps must have receipts).

I certify that I have provided the services listed above.

Provider's signature _____ Date _____

**For additional information, visit http://MyAssurantBenefits.com and click the Flexible Spending link**

**Attn: Assurant, Inc.** Attn: Flexible Spending, 6941 Vista Drive, West Des Moines, IA 50266

(11/2015)