Dependent Care Flexible Spending Account Form

How to file a claim:

Online: The fastest way to receive reimbursement for your completed claim is through the web or MyChoice® Mobile App. Reimbursement for completed claims submitted via web or mobile app is processed within 2 – 3 business days.

Via email, mail or fax: Fill out your form electronically and submit via email, mail or fax. Completed claims submitted via email, mail or fax may take up to 7 – 10 business days to process.

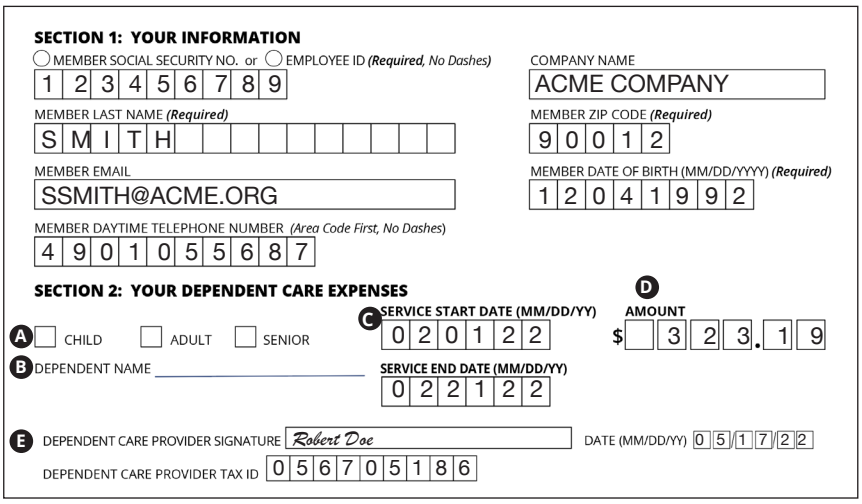
- **Email**: claims@mychoiceaccounts.com
- **Mail**: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax**: 855-883-8542

Instructions for filling out this form:

Complete each section completely. If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

- **A** DEPENDENT TYPE
- **B** DEPENDENT NAME
- **C** SERVICE START AND END DATE
- **D** AMOUNT SUBMITTED FOR CLAIM
- **E** DEPENDENT CARE PROVIDER SIGNATURE *(not required if sufficient documentation is provided)*



SECTION 1: YOUR INFORMATION

○ MEMBER SOCIAL SECURITY NO. or ○ EMPLOYEE ID *(Required, No Dashes)*: 1 2 3 4 5 6 7 8 9

COMPANY NAME: ACME COMPANY

MEMBER LAST NAME *(Required)*: S M I T H

MEMBER ZIP CODE *(Required)*: 9 0 0 1 2

MEMBER EMAIL: SSMITH@ACME.ORG

MEMBER DATE OF BIRTH (MM/DD/YYYY) *(Required)*: 1 2 0 4 1 9 9 2

MEMBER DAYTIME TELEPHONE NUMBER *(Area Code First, No Dashes)*: 4 9 0 1 0 5 5 6 8 7

SECTION 2: YOUR DEPENDENT CARE EXPENSES

D AMOUNT: $ 3 2 3 . 1 9

A ☐ CHILD ☐ ADULT ☐ SENIOR

C SERVICE START DATE (MM/DD/YY): 0 2 0 1 2 2

B DEPENDENT NAME _____

SERVICE END DATE (MM/DD/YY): 0 2 2 1 2 2

E DEPENDENT CARE PROVIDER SIGNATURE: *Robert Doe*

DATE (MM/DD/YY): 0 5 / 1 7 / 2 2

DEPENDENT CARE PROVIDER TAX ID: 0 5 6 7 0 5 1 8 6

Submitting a completed claim:

To ensure your claim is complete, and can be processed as quickly as possible, provide all information as required in Your Information section, and all necessary information as required for a claim being submitted for your eligible dependent(s). **If any of the required documentation or information is missing, your claim will not be complete and may be delayed in processing.**

Below are 5 pieces of information that must be included in the documentation submitted with your claim:

1. Name of dependent(s) for whom the expense was incurred
2. The date the expense was incurred (not the date paid and no future dates)
3. The name of service provider
4. A description of the service and/or expense
5. The amount of the expense for which you are responsible

Note: If submitting a claim for the entire calendar year, please enter the start date as the first date claim will be incurred and end date as the last date of services provided. Claim will be prorated over the service period and paid out as contributions are reported.

Members can submit dependent care flex spending account claims for the following under IRS Code Section 132: A "qualifying child or dependent" is someone whose principal place of abode is with you; who is under age 13, or physically/mentally incapable of caring for him/herself and doesn't have income in excess of IRS tax code.

Examples of qualifying expenses

1. Child care services while you are working, such as preschool or daycare expenses, before and after school programs, day camp or care of disabled or senior live-in dependents.
2. Child/Dependent Care—If your provider can sign and provide tax ID on the request form you will not be required to submit additional documentation.

Please Note: Canceled checks, credit card receipts and balance forward statements are NOT acceptable forms of documentation.

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SECTION 1: YOUR INFORMATION

◯ MEMBER SOCIAL SECURITY NO. or ◯ EMPLOYEE ID ***(Required, No Dashes)***

COMPANY NAME

MEMBER LAST NAME ***(Required)***

MEMBER ZIP CODE ***(Required)***

MEMBER EMAIL

MEMBER DATE OF BIRTH (MM/DD/YYYY) ***(Required)***

MEMBER DAYTIME TELEPHONE NUMBER *(Area Code First, No Dashes)*

SECTION 2: YOUR DEPENDENT CARE EXPENSES

☐ CHILD ☐ ADULT ☐ SENIOR

DEPENDENT NAME _____

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT $.

☐ CHILD ☐ ADULT ☐ SENIOR

DEPENDENT NAME _____

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT $.

☐ CHILD ☐ ADULT ☐ SENIOR

DEPENDENT NAME _____

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT $.

DEPENDENT CARE PROVIDER SIGNATURE

DATE (MM/DD/YY)

DEPENDENT CARE PROVIDER TAX ID

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.

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MCA-DCFSA