QualCare, Inc.
Flexible Spending Account – DEPENDENT CARE CLAIM FORM

Submit Claims to:
QualCare, Inc.
PO Box 639
Piscataway, NJ 08855-0639

TOTAL AMOUNT OF REIMBURSEMENT REQUESTED $

Participant Information

Name: _____
Last First MI

Home Address: _____
Street City State Zip

Social Security #: _____-_____-_____ **Employer:** **QualCare, Inc.**

☐ Check if this is a change in address **Ext.:** _____

Helpful Hints to Ensure An Expedited Reimbursement

IRS regulation requires services to have been rendered in order to be reimbursable. Therefore, we are unable to issue any benefits for services that have not been provided. The care must be for your dependent under the age of 13 or for your incapacitated dependent or spouse who is unable to care for himself/herself. Additionally, the following services are **not** reimbursable under your dependent care account:

- Registration Fees
- Lessons
- Payment Fees
- Meals
- Overnight Camp Expenses
- Educational Expenses
- Transportation Expenses

Reimbursement Guidelines

Please have your day care provider sign below in the "Provider Signature" section. If your provider does not sign in the "Provider Signature" section you must attach a bill or receipt showing **ACTUAL DATES OF SERVICE** (not the date you paid the provider), cost, and the care provider's tax ID or Social Security number. ***PLEASE USE ONE FORM PER DEPENDENT.**

Provider Certifies that I am a qualified provider as defined by the Internal Revenue Code, and that the expenses for services claimed below have actually been provided.

Provider's Signature _____ **Date** _____

Beginning Date of Service ___/___/____ Ending Date of Service ___/___/____	Description Of Expense	Provider's Name	Providers Social Security or Tax ID _____
Dependent's Date of Birth _____/_____/_____	Dependent's Name	Grade ____ Disabled Y/N	Amount Requested $_____
Beginning Date of Service ___/___/____ Ending Date of Service ___/___/____	Description Of Expense	Provider's Name	Providers Social Security or Tax ID _____
Dependent's Date of Birth _____/_____/_____	Dependent's Name	Grade ____ Disabled Y/N	Amount Requested $_____

Please read the following and then sign this form.

I certify that all services for which reimbursement is requested under the FSA Plan were incurred by myself or my eligible dependents within the Plan Year of my election, that the expenses associated with these services have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage. I will not use qualifying medical expenses reimbursed through my medical reimbursement account or my dependent care reimbursement through my dependent care assistance account as deductions when filing my Federal Income Tax return.

I understand that I am fully responsible for the sufficiency and accuracy of all information relating to medical and dependent care which are provided by me, and that unless expense is a qualifying expense under the FSA, I may be liable for payment of all related taxes and penalties.

Signature:_____ Date:_____