



REIMBURSEMENT REQUEST
DEPENDENT CARE FLEX SPENDING ACCOUNT
FAX TO 951-656-9276

FAX THIS FORM (& DOCUMENTATION IF REQUIRED) -NO COVER SHEET NECESSARY IF A SINGLE PAGE

PAGE 1 OF _____ PAGES

EMPLOYEE INFORMATION

Employer Name _____

Employee Name _____ Last 4 Digits of SSN _____

Address, City State & Zip (if we do not already have it) _____

Phone Number _____

What is your email address _____

Claim Information

Day Care Provider _____ Tax ID # or SSN _____

Address, City, State & Zip _____

Table with 4 columns: Dependent Name, Date of Birth, Date(s) of Service (MM/DD/YYYY), Requested Amt. Includes rows for individual dependents and a Total Amount Requested \$.

Provider Certification

I certify that the above services have been provided:

Provider Signature _____ Date _____

IF THE PROVIDER SIGNS THIS CLAIM FORM, ADDITIONAL DOCUMENTATION IS NOT REQUIRED.

- My provider has signed the claim form
I have attached the itemized receipt(s) or statement(s) from my day care provider

Employee Certification & Agreement:

I attest to the fact that the expenses I am requesting reimbursement for are eligible expenses under the Internal Revenue Code and my Employer's Flex Plan. These expenses are for services that have already been provided. These expenses will not be claimed under another plan nor have they previously been claimed under this, or another plan. I understand that these expenses may not be used to claim a deduction or credit on my federal tax return, and I agree that I will file the IRS form 2441 with my tax return. I understand that unused contributions are forfeited to my employer at the end of the plan year. I further understand that any amount I receive over the statutory limits may not be excluded from my income and my maximum allocation may not exceed the earned income limitation as described in the Summary Plan Description. I agree that if my employer has adopted a grace period, I understand that expenses incurred and approved during the grace period will be paid first from available amounts that were remaining at the end of the plan year to which the grace period relates to and then from any amounts that are available to reimburse expenses incurred during the plan year. I also understand that claims will be paid in the order in which they were received. I agree and understand that in the event of an erroneous or excess reimbursement, I am required to reimburse the Plan for the improperly paid amount. I further agree that failure to repay the plan could result in adverse tax consequences. I lastly agree that if I have provided my email address, I authorize PayPro Administrators to send account information to me via email.

Employee Signature Date _____

Date _____

Fax this form to 951-656-9276 or email this form to CLAIMS@PAGROUP.US
PAYPRO ADMINISTRATORS 951-656-9273, 800-427-4549, WWW.PAGROUP.US
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