Request for Reimbursement
Family Care Spending Account

Instructions

1. Employee must complete **Employee Information**.

2. Complete **Claim Information** in its entirety. Please ensure your supporting documentation clearly indicates the requested amount.

   Eligible expenses are defined in your Summary Plan Description. Such expenses include, but are not limited to after-school care, extended day programs, au pair services, babysitter in or out of the home, nanny day care expenses, sick child facility, and summer day camp for your qualifying child who is age 12 or under. Also eligible, custodial or elder day care expenses of a qualifying individual, educational expense for pre-school / nursery school, FICA / FUTA taxes of the day care provider.

   Ineligible expenses include but are not limited to assisted living expenses, airfare, living expenses or other fixed costs for a nanny or au pair, gardening services, housekeeping services, kindergarten expenses, nursing home expenses, overnight camp expenses, meals, registration fees and educational expenses (tuition).

   NOTE: There is a special rule for children of divorced parents. The child is a qualifying individual of the "custodial parent", as defined in Code Section 152(e).

3. Check the appropriate box in **Provider Certification**. If both the employee and provider certifications are completed and signed, additional documentation is not required. For claim forms without the provider's signature, an itemized statement from the dependent care provider is required. Itemized statements should include the date(s) of service, the name and date of birth of the dependent, itemization of charges and the provider's name, address, and Tax ID/SS number. If mailing small receipts, we suggest you tape them to a standard size sheet of paper. However, faxing the claim will produce a quicker turnaround time.

4. Sign and date **Employee Certification**.

5. **Submit Claims To**:

   Empire BCBS
   Fax: (888) 347-5212 Phone: (877) 378-2448
   P.O. Box 660165
   Dallas, TX 75266-0165

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Empire BlueCross BlueShield

Request for Reimbursement
Family Care Spending Account

Employee Information

Employer Name ______________________________

Employee Name ____________________ Account Number / SSN ____________________

Street Address ____________________ Daytime Phone Number ____________________

City ____________________ State __________ Zip Code __________

Do you want to know if Empire received and processed your claim? Please provide your e-mail address:

E-mail Address ______________________________

Claim Information

Day Care Provider ____________________ Tax ID Number / SSN ____________________

Street Address ____________________ City ____________ State ______ Zip Code ________

Dependent Name	Date of Birth	Date(s) of Service (MM/DD/YYYY)		Requested Amount
		From:	To:	$
		From:	To:	$
		From:	To:	$
		From:	To:	$

Total Amount Requested* (Continue on additional page if necessary) $ __________

Provider Certification

I certify that the above services have been provided.

Provider Signature ______________________________ Date ____________

If the provider signs the claim form, additional documentation is not required.

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

Employee Certification

- I certify the expenses listed for reimbursement are eligible family care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan ("Plan");
- I certify the services listed above have been received by my qualifying individual (as defined in the Summary Plan Description);
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the family care expenses reimbursed may not be used to claim a deduction or credit on my federal income tax return;
- I agree to file IRS Form 2441 with my tax return and make reasonable attempts to obtain the care provider's tax identification number;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand 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;
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I also understand failure to repay the Plan could result in adverse income tax consequences;
- By providing my e-mail address, I authorize Empire to send account information to me via e-mail.

Employee Signature ______________________________ Date ____________

Fax: (888) 347-5212 Phone: (877) 378-2448

* Only the "Amount Requested" will be paid, rather than the "Total Charges" for all "Date(s) of Service."

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