Dependent Care Flexible Spending Account Reimbursement Form

Instructions

This form is for reimbursement of any out-of-pocket expenses where your Forma Benefits Card was not used, and you do not have a detailed itemized receipt. Please submit this form with your supporting documents, including invoice and bank statements, as proof of the payment via https://client.joinforma.com/claims.

The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, as described further in the Salary Reduction Plan Summary Description.

Should you have any questions, please contact our Customer Support team via Live Chat or email to support@joinforma.com.

Section 1

Employee Full Name:	Employer Name:
Email Address:	Phone Number:

By signing and submitting this DCFSA Reimbursement Form, I am certifying that expenses for which I request reimbursement satisfy all of the following conditions.

Each person for whom I incur the expenses is a Qualifying Individual – that is, he or she must be:

- a person under age 13 who is my “qualifying child”;
- my Spouse or domestic partner who is physically or mentally incapable of self-care and has the same principal abode as me for more than half of the year; or
- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as me for more than half of the year, and is my tax dependent under the Code.

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the child as a dependent.

The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed.

The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child, or a person whom you (or your Spouse) can claim as a dependent for federal income tax purposes. If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.

To the best of my knowledge, my statements in this form are true and complete. I certify that these expenses have not previously been reimbursed under this or any other plan, and I will not seek reimbursement for them under any other benefit plan (including a plan through my employer or through a spouse, domestic partner or parent). I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Employee Signature Verification X________________________

Date__________________ Required to process reimbursements

Section 2

Date of Service	Dependent's Name	Description of Service	Amount of Service
			$
			$
			$
		Total Amount of Reimbursements	$

Dependent Care Receipt

Instructions

THIS IS NOT A CLAIM FORM. If your dependent care provider does not give you a receipt, have them complete and sign this form. You may use this for documentation for dependent care expenses paid with your Forma Benefits Card, or to get reimbursed for your out-of-pocket expenses. Please submit this form with your supporting documents, including invoice and bank statements, as proof of the payment via Forma portal. Should you have any questions, please contact our Customer Support team via Live Chat or email to support@joinforma.com.

Participant Information

Name: ________________________/ Employer: ________________________

Care Services Information

Service Start Dates: ________________________/ Service End Date: ________________________

Service Description: _______________________ / Dependents' Names: ______________________

Fees: $____

Provider Information

Name: ________________________/ SSN/Tax ID#: ________________________

Address: ____

Signature

Signature of Participant certifying all above information is accurate (required):

Signature: ____ Date: _______________________

Signature of Provider certifying all above information is accurate (required):

Signature: ____ Date: ______________________