FLORIDA

Flexible Spending Account Claim Form
Dependent Care

Employee's Name: _____

Social Security Number: _____-_____-_____

Employee's Daytime Phone: (_____) _____-_____

Please refer to the instructions on the back of this form to ensure you attach all required documents.

Dependent's Name	Sex	Birthdate	Provider Information
1)			Dependent Care Provider's Name: _____ Address: _____ Provider Federal Tax ID# or SSN: _____ Dates of Service: From _____ to _____ Amount Requested: $_____
2)			Dependent Care Provider's Name: _____ Address: _____ Provider Federal Tax ID# or SSN: _____ Dates of Service: From _____ to _____ Amount Requested: $_____
3)			Dependent Care Provider's Name: _____ Address: _____ Provider Federal Tax ID# or SSN: _____ Dates of Service: From _____ to _____ Amount Requested: $_____
4)			Dependent Care Provider's Name: _____ Address: _____ Provider Federal Tax ID# or SSN: _____ Dates of Service: From _____ to _____ Amount Requested: $_____

Are you or any member listed above covered by another insurance plan?

Medical: ☐ Yes ☐ No

Dental: ☐ Yes ☐ No

Vision: ☐ Yes ☐ No

If "yes," please enclose a copy of your other carrier's Explanation of Benefits (EOB).

EMPLOYEE CERTIFICATION

I authorize my Flexible Spending Account (FSA) to be reduced by the amount of expenses listed above. The expenses incurred by myself or my eligible dependents are not reimbursable from any other source. I understand that these expenses cannot be claimed as credits or deductions on my income tax return. I further certify that I have read and understand the information outlined on the back of this form. The information on this form is true and correct to the best of my knowledge.

Employee's Signature:_____ Date:_____

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How to File This FSA Claim Form

1. Attach a copy of your itemized bill from the provider with this information:
    a. Name and address of the provider
    b. Social Security Number or federal tax identification number of the provider
    c. Detailed statement of services rendered, with dates of services
2. Mail the completed FSA Claim Form, along with a copy of the provider's itemized bill, to the address listed below.
3. Keep copies of all claims submitted. We will not return documentation mailed with this claim form.
4. You must submit all FSA claims by the last day of the specified run-off period of the following year for expenses incurred during the plan year. Check with your company's Human Resources department for the exact date your run-off period ends. Any money remaining in your account after the end of the plan year will be forfeited under Internal Revenue Service (IRS) guidelines.

Dependent Care Reimbursement

- Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a disabled parent for whom you are entitled to a personal tax exemption as a dependent.
- To be eligible, you must be working while your dependents receive care. Also, if you are married, your spouse must be one of these:
    - A wage earner.
    - A full-time student for at least five months during the year.
    - Disabled and unable to provide for his or her own care.
- Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:
    - Licensed nursery schools and day care centers.
    - Individuals (other than your dependents under age 19) who provide care for your children in or outside your home, or for your disabled spouse or dependent parent in your home.
    - Housekeepers, maids or cooks in your home, to include their food and lodging in your home, as long as their services are performed for the benefit of your eligible dependent(s).
- Under IRS regulations, the reimbursement when aggregated with all other dependent care reimbursement during the same year may not exceed the lesser of the these limits:
    1. $5,000.
    2. $2,500 if you are married and your spouse files a separate tax return.
    3. If you are single, your taxable compensation.
    4. If married, the lesser of your earned income or your spouse's earned income for the year.
- IRS regulations limit the amount of reimbursement expenses for dependent care to the lower of the annual earned income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns $200 per month (one dependent) or $400 per month (two or more dependents). Under IRS regulations, qualified individuals can receive a tax credit for some dependent care costs. You can claim this credit on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the FSA, since FSA funds are pre-tax withholdings.

How to Contact Us

Mailing address:

Columbia Service Center
P.O. Box 100237
Columbia, SC 29202

Secure fax: 803-264-6423
Phone: Toll free 800-300-5248

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
