AULTCARE

DEPENDENT CARE FLEXIBLE SPENDING CLAIM FORM

Employee Name	Member ID
Place of Employment	Group Number

To submit dependent care account claim form you must:

1. Complete this form.
2. Submit an itemized bill or receipt from the provider containing the following information:
   a. Person or institution providing day care.
   b. Amount charged for service.
   c. Dates of service.
   d. Name of person/child receiving service.
3. Retain copy for your records.

DEPENDENT CARE EXPENSES			
Charge Amount	Dependent Name	Relationship to Employee	Date of Birth

I certify these expenses have been incurred to care for my eligible dependent(s) under the age of 13 years and have been previously reimbursed and are not eligible for reimbursement through any other plan. I certify either I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement under any other plan. Furthermore, I declare I will not deduct these expenses on my own or anyone else's individual federal income tax return.

Employee's Signature _____ Date _____

BANKING INFORMATION FOR DIRECT DEPOSIT	
If you have not previously provided your banking information for direct deposit payments, please provide:	
Bank Name	
Routing Number	Account Number
Account Type ☐ Checking ☐ Savings	***Please attach a copy of a check, if new or changed **

I authorize my employer to make the changes listed above for the direct deposit of my flexible spending check(s). Signature below is REQUIRED.

Employee's Signature _____ Date _____

SUBMIT CLAIM TO:
AULTCARE FLEXIBLE SPENDING ACCOUNT
PO BOX 6910 | CANTON OH 44706 | FAX 330-470-4757
ancillaryclaimsservices@aultcare.com