



P.O. Box 348
 One Dodge Street
 North Greenbush, NY 12198
 (518) 283-8500
 Fax (518) 283-2393
 800-698-4753
 claims@benetech.cc

Flexible Spending Account

DEPENDENT CARE EXPENSE RECOVERY FORM

EMPLOYER (COMPANY) NAME AND ADDRESS: _____

EMPLOYEE NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____
(street) (city) (state) (zip)

If new, check here

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT RELATIONSHIP TO EMPLOYEE: _____ CHILD SPOUSE OTHER: _____
(please specify)

When submitting this form you must complete the information requested below and attach an ITEMIZED RECEIPT, CANCELLED CHECK OR OTHER PROOF OF PAYMENT.

| DATES OF SERVICE | NAME OF PROVIDER and Tax ID # | AMOUNT REQUESTED FOR REIMBURSEMENT |
|------------------|----------------------------------|------------------------------------|
| | | |
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By signing and submitting this form you acknowledge that all requirements of Section 213 of the IRS code, as well as the plan document of your employer, have been satisfied.

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse my employer and/or the administrator to the extent of an overpayment which is in excess of the amounts payable under the plan.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR ADMINISTRATOR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE: _____ DATE _____