FLEXIBLE BENEFITS PLAN CLAIM FORM
DEPENDENT CARE REIMBURSEMENT

Please complete form in full, sign/date & attach supporting documentation for each expense.

Employee Information	Social Security Number	Full Name	Daytime Phone Number
Employer			Home Phone Number
Full Home Address			☐ **Check if New Address**
E-mail Address			☐ **Check if New E-mail Address**

*** You will receive notification by email when you claim is received and another when a payout is sent. You will also receive email notification of direct deposits. Be sure your email address is current and legible.**

Dependent Information	Dependent's Full Name	Relationship to Employee ☐ Spouse ☐ Child ☐ Other	Date of Birth	Age
	Date(s) of Service (MM/DD/YY) From _____ Through _____		**Amount Submitted** $_____	
	Dependent's Full Name	Relationship to Employee ☐ Spouse ☐ Child ☐ Other	Date of Birth	Age
	Date(s) of Service (MM/DD/YY) From _____ Through _____		**Amount Submitted** $_____	
	Dependent's Full Name	Relationship to Employee ☐ Spouse ☐ Child ☐ Other	Date of Birth	Age
	Date(s) of Service (MM/DD/YY) From _____ Through _____		**Amount Submitted** $_____	
	TOTAL DEPENDENT CARE COSTS INCURRED: $_____			

Provider Information	**Provider Name**	Is the Provider a Relative over the age of 19? ☐ Yes ☐ No
	Social Security Number or EIN Number (<u>required or claim will be denied</u>)	
	Address of Provider	**Provider Phone Number** ( )
	Provider Signature	**Date**

Employee Certification

I certify that I have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account and I further declaim that I have not and will not claim credit for these expenses on my individual tax returns. I further certify that I have read and understand the limitations on reimbursements from my Flexible Spending Account on the reverse side of this form for dependent care expenses and that I am eligible to receive benefits under this program. I also certify that the above dependent care expenses are for the care of qualifying individuals and do not include separate charges for food, clothing, education, entertainment, activities, late fees, transportation, housekeeping or overnight care. **Please review eligibility information on the reverse side.**

Signature_____ **Date**_____

Claim Return Policy

If you submit a claim for an expense that is determined ineligible, for a time when you were not enrolled in the plan or submitted with insufficient documentation, PRN may request additional information to substantiate the claim. We will include an explanation of any corrective measures (if any) you must take before the claim can be processed. Please make necessary corrections and return the form. The claim will be processed on the next regularly scheduled processing date.

Claim Submission

PLEASE MAIL CLAIM FORMS AND SUPPORTING DOCUMENTATION TO:
Phillips Resource Network Flex Department, PO Box 653, Overland Park, KS 66201-0653
Telephone: 913.236.7777 Email: PRNS125@phillipsresource.com
Fax: 913.261.0083

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