MAIL TO:
Blue Cross and Blue Shield of Florida
Spending Account Administration
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BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Dependent Care (Daycare) FSA Reimbursement Request Form

For Dependent Care Flexible Spending Accounts ONLY

PLEASE PRINT AND COMPLETE THIS FORM IN ITS ENTIRETY, AS INCOMPLETE FORMS WILL BE RETURNED.

For Dependent Care (Daycare) Flexible Spending Account (FSA) reimbursement, you have two options: 1) You may use this form as your Dependent Care receipt, by completing the Dependent Care Provider Information below. Then have your Dependent Care provider sign the provider's line after validating the information you complete, or 2) You may use this form AND attach a detailed receipt from your Dependent Care Provider which shows their name, phone number, address, tax I.D. number and the name of the person for whom care was furnished, the dates of service and the amounts charged. **Generic "cash receipts" cannot be accepted.**

Employee's Name: (Last Name, First Name, Middle Initial)	**Social Security Number:**
Employer's Name:	

Dependent Information

Are any of your dependents college students under age 25? ❑ Yes ❑ No
Does the dependent(s) you are claiming live in your household? ❑ Yes ❑ No
Do you provide more than one-half of the support for the dependent(s) during the year? ❑ Yes ❑ No

Requested Reimbursement Expenses

Dependent's First & Last Name	Relationship To Employee	Birth Date	Dependent Care Provider (Circle A or B)	Date of Service* (Month/Day/Year) From – To	Amount	Description of Expense	BCBSF Use only
			A or B		$		
			A or B		$		
			A or B		$		
			A or B		$		
			A or B		$		
*Service must be totally rendered and completed before payment on any part can be made.					**$**	**TOTAL**	

Dependent Care Provider Information

(A) Name of Dependent Daycare Provider		(B) Name of Dependent Daycare Provider	
Address of Provider	Tax ID or SSN	Address of Provider	Tax ID or SSN
Phone #	Date	Phone #	Date
Signature of Provider (Please validate service dates and amounts)		**Signature of Provider (Please validate service dates and amounts)**	
Complete only if Provider is related to you: Can he/she be claimed on your Federal Income Tax? __ Yes __ No Age: ________ Relationship to you: __________________		**Complete only if Provider is related to you:** Can he/she be claimed on your Federal Income Tax? __ Yes __ No Age: ________ Relationship to you: __________________	
Note: Eligible dependents ARE under age 13, unless disabled. If disabled, identify disability and provide name and address of certifying physician.			

Employee Signature Required Below

I certify that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account plan; and that such expenses have not been reimbursed, and are not reimbursable from any other source. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made.

I hereby authorize any individual or organization to release any information requested by Blue Cross and Blue Shield of Florida with respect the claims on this specific application.

Employee Signature: ___________________________ Day Phone #: ____________ Date: ________

FOR BCBSF USE ONLY

Processor's Name: ________________________________ Request ID: _______________________ Date Processed: _________________

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