

GETTHEALTH FSA DEPENDENT CARE EXPENSE CLAIM FORM INSTRUCTIONS

HOW TO FILL OUT YOUR DEPENDENT CARE EXPENSE CLAIM FORM

- 1) Attempt to use your GettHealth Flex Convenience Debit Card (if applicable) to pay claim – if you cannot use your card, please wait until you have accumulated a minimum of \$50 in outstanding claims, before sending in paper receipts for reimbursement.

If you cannot use your GettHealth Flex Convenience Debit Card Follow the Easy 3 Step Process:

- 2) Complete the attached GettHealth FSA Dependent Care Expense Claim Form.
- 3) Please photocopy receipts from time of service.
- 4) Fax **Completed Claim form** and **receipts** to: **888-298-1591**

OR IF FAX IS UNAVAILABLE, MAIL TO:

- 5) Send **Completed Claim Form** and **Original Receipts** to:

Gettysburg Health Administrators, Inc.
Attn: FSA Administrator
PO Box 1060
Gettysburg, PA 17325

GETTHEALTH FSA DEPENDENT CARE EXPENSE FORM

Social Security No.: _____ Group Name.: _____

Participant's Name: _____
Last First Middle

To: Gettysburg Health Administrators, Inc.
 PO Box 1060
 Gettysburg, PA 17325
 FAX: 888-298-1591

The undersigned participant in the Plan requests reimbursement in the amounts shown below: (If additional space is needed please use the attached sheet.)

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by other coverage. Also, you will not be entitled to claim any reimbursed expenses as a tax deduction.

DEPENDENT CARE EXPENSE

Dependent name:	Dates of Service _____ to _____	Amount: \$ _____
Provider Name	Provider SSN or TIN:	Provider Signature:

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Provider Name	Provider SSN or TIN:	Provider Signature:

Dependent name:	Dates of Service _____ to _____	Amount: \$ _____
Provider Name	Provider SSN or TIN:	Provider Signature:

Total Dependent Care Expenses: \$ _____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

 Employee's signature

 Date

DEPENDENT CARE EXPENSE

Dependent name:	Dates of Service _____ to _____	Amount: \$ _____
Provider Name	Provider SSN or TIN:	Provider Signature:

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