Beneflex

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Email submission to: claims@flexaccount.com or Fax: (732) 428-8111

GRACE PERIOD
DEPENDENT CARE ACCOUNT REIMBURSEMENT CLAIM FORM…

FOR GRACE PERIOD PARTICIPANTS ONLY!
IF YOUR PLAN DOES NOT INCLUDE A GRACE PERIOD USE A STANDARD CLAIM FORM

Part I: Employee Information

Company Name	Employee Name(Last, First)	Social Security Number
Employee e-mail Address	Contact Number	
IF ANY OF THE INFORMATION ABOVE NEEDS ALTERATION PLEASE COMPLETE A CHANGE APPLICATION FORM		

*** Grace Period Claims with no designation will be reimbursed with funds from the year of service.***

Grace Period Claims Must Designate a Plan Year >>>>>>>	**Plan Year**

Part II: Dependent Care Reimbursement Request

	Dates of Service Beginning Date to Ending Date	Provider's Name	Provider Tax ID #	Dependent's Name and relationship	Total Amount Requested
1					
2					
3					
4					
5					
	Total Reimbursement Requested >>>				$

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM

IMPORTANT INFORMATION REGARDING THE USE OF THIS FORM

* IF YOUR COMPANY PLAN INCLUDES A GRACE PERIOD USE THIS FORM FOR REIMBURSEMENT.
* SERVICE DATES AFTER THE GRACE PERIOD HAS EXPIRED WILL BE REIMBURSED WITH FUNDS FROM THE YEAR SERVICE OCCURRED.
* GRACE PERIOD CLAIMS SUBMITTED FOR REIMBURSEMENT AGAINST THE PRIOR PLAN YEAR THAT ARE IN EXCESS OF THAT YEARS AVAILABLE BALANCE WILL BE CHARGED FIRST AGAINST THE PRIOR YEAR BALANCE AND THEN TO THE CURRENT PLAN YEAR (SO LONG AS YOU ARE PARTICIPATING AND HAVE A SUFFICIENT BALANCE IN THE CURRENT PLAN YEAR).
* CLAIMS ARE ENTERED 48-72 HOURS AFTER RECEIPT. VISIT **WWW.FLEXACCOUNT.COM** FOR CLAIM STATUS AND BALANCE INFO.

I understand that:

* I may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan which relate to such expense if the expense is not a qualifying expense under the Plan.
* I am responsible for and liable to the Employer and/or BeneFlex, Inc. for any reimbursement I may receive in excess of my contributions to such Plan.

* Reimbursement of Dependent Care expenses will reduce and may eliminate completely my ability to claim a dependent care credit on my personal income tax return;
* Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; and
* I hereby authorize release of payment through my Flexible Spending Account(s).

Employee Signature: ____ **Date:** ________________________