# of Pages (including this Claim Form): _____

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FSA – DEPENDENT CARE CLAIMS FORM

Instructions: Reimbursement are made on the 1st and 15th of every month for claims submitted in the previous 15 days. Please send this completed form with proper documentation to ***RPG Consultants – FSA Department at the address above***. Please keep a copy of all correspondence for your records. Copies of this form are available at www.rpgconsultants.com.

Documentation: You must complete this form and attach documentation to ensure timely reimbursement. You should attach receipts, cancelled checks or bills (if available). You must include the Tax ID # or SS# of the provider.

Eligible Expenses: Please refer to our website at www.rpgconsultants.com for more information. You may also e-mail us at fsa@rpgconsultants.com with any questions. Your contact information below will be used if there are questions about your claim.

Employee Information:

Name:_____ Company Name: _____

SS:_____ Date of Birth:_____ Check one: _____Married _____Single

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ E-mail:_____

Dependent Name	Relationship	Date of Birth	Dates of Care (from/to)	Name/Address of Provider/Facility	Tax ID or SS#	Amount

(Additional expenses should be placed on separate forms. Each form treated as individual claim)

Total Dependent Care Expenses: $_____

If day care is provided by one of your children, please give that child's age. _____

I request reimbursement for the attached expenses under my Dependent Care Expense Reimbursement Expense Account. I certify that these expenses are for dependent care as defined by the Internal Revenue Service. Furthermore, I declare that these expenses have not been reimbursed from any other source nor do I expect them to be.

Signature: _____ Date: _____

For Official Use Only: Date Received: _____ Date Processed: _____ Processed By: _____ rev. 4/2015