Return the completed Claim Form and documentation to:
Toni Ann Amature, Benefits Administrator
Independent Pension Services, Inc.
114 Old Country Rd., Ste. 520, Mineola, NY 11501
Phone: 516-747-5210 Fax: 516-385-2124
Secure Email: https://independentpension.securefilex.com

DEPENDENT CARE FSA CLAIM FORM

I. Participant Identification (Please print or type)

Company/Location: _____

Participant Name: _____

Mailing Address: _____

_____

Social Security Number: ___-___-___ Email: _____

II. Invoices attached (Please attach a separate sheet if more space is needed)

Date of Service	Child Care Facility Name	Tax ID	Amount
_____	_____	_____	$ ____.____
_____	_____	_____	$ ____.____
_____	_____	_____	$ ____.____
_____	_____	_____	$ ____.____

III. Total Amount Requested

$ ____.____

IV. Statement by Participant

To the best of my knowledge and belief, my statements in this Form are complete and true, and I certify the following: my family member has received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Dependent Care Expenses under the Plan. These expenses have not been reimbursed or are not reimbursable under any other plan. I understand that the expenses I am reimbursed may not be used to claim any federal income tax deduction or credit.

_____ _____
Participant's Signature Date

For administrative use only
Reviewed by: IPS/TONI ANN Date: _____ Plan Year: _____ Benefit: DCARE FSA
Approved: $_____.___ Denied: $_____.___
Reason For Denial: _____ Action To Be Taken: _____