Flexible Spending Account Dependent Care Claim Form

Your Name:	Employer:
Email Address:	Date:

Dependent Name	Age	Provider Name	Date of Service	Requested Amount
				$
				$
				$
				$
				$
			Total Requested	$

Provider Certification/Verification (*If no receipt is available*):

I certify that the dependent care expenses listed above were incurred by the participant named above.

Provider Address: _____

Provider Signature: _____ Date: _____

Participant Authorization:

I hereby certify that the reimbursement requests above are for items or services covered under my employer's plan and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from any other source. I also understand that RSS Agency, Inc., its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. This request cannot be accepted without participant's signature:

Employee Signature:_____ Date:_____

RSS Agency
380 Washington Avenue Kingston, NY 12401
Phone (845) 481-4036 Fax: (845) 334-3703