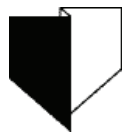


FSA



**MERITAINSM
HEALTH**

**Dependent Care
Request for Reimbursement**

Complete and send to:
Meritain Health
Flexible Spending Accounts
PO Box 30111
Lansing, MI 48909
Fax: 1.888.837.3725

NOTE: Refer to your flexible spending account plan booklet for minimum and maximum dollar amount requirements for submitting expenses. Make copies of bills, receipts, and other supporting documentation for your files, as they will not be returned.

EMPLOYEE INFORMATION			Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name (last, first, initial)		Sex	Employer Name/Location	
Home Address		Identification Number	Birthdate	Group/Member No.
City	State	ZIP Code	Work Telephone () ()	Home Telephone () ()
Dependent's Name(s) (last, first, initial)		Dependent Age	Relationship to employee	

DEPENDENT CARE ACCOUNT EXPENSES

Attach an itemized receipt for each expense listed. Reimbursement will only be considered for expenses incurred within the dates you participate in this plan. Refer to your plan booklet for details on how long after your participation ends that you may submit eligible expenses.

Dependent Care Provider Information

Name		Tax Identification or Social Security Number		
Address				
City	State	ZIP Code	Telephone	
Type of Service	Date(s) Incurred (From/To)		Amount	
		/		

Dependent Care Provider Information

Name		Tax Identification or Social Security Number		
Address				
City	State	ZIP Code	Telephone	
Type of Service	Date(s) Incurred (From/To)		Amount	
		/		

EMPLOYEE'S SIGNATURE REQUIRED

It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts. I certify that the above information is correct. I also certify that I have not received nor will seek reimbursement previously for these expenses from the FSA or any other plan, and I know of no fact that makes me question whether this expense is properly reimburseable under the plan. I understand that reimbursement is not a guarantee that this payment is tax-free, and that reimbursed expenses cannot be used to claim a credit or deduction on my personal income tax return.

Signature _____ Date _____

Meritain Health Toll-Free Customer Service: 800-748-0003