P. O. Box 4346, Missoula, MT 59806

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:
www.allegianceflexadvantage.com

FAX: 406-523-3149 or, toll-free 877-424-3539 PHONE: 406-721-2222 or, toll-free 877-424-3570

Please print legibly in black or blue ink. Do not include medical expenses on this form.
Do not use a highlighter on this form.

Employer Name: ___________________________ Total # of Pages Submitted: _____

Employee Name: __________________________ Please call to confirm receipt? Yes ☐

Employee ID: ____________________________
(Social Security Number or, if assigned, alternate ID) Return Phone Number:_____-_____-_______

Comments: ______________________________ Attention: _____________________________

PLEASE SEE REVERSE FOR CLAIM FILING INSTRUCTIONS. Use one service line for each different provider. List the service dates, fees charged, first name of each child in care, and provider name and signature**. * If these expenses are consistent each month you may use our convenient daycare reimbursement contract- see www.allegianceflexadvantage for filing instructions.**

SERVICE DATES (mm/dd/yy)	FEES	INDIVIDUALS IN CARE	PROVIDER	PROVIDER SIGNATURE (if bill/receipt not attached)
________ to ________	$________	__________________	Name____________________	______________________
		__________________	Tax ID __________________	______________________
________ to ________	$________	__________________	Name____________________	______________________
		__________________	Tax ID __________________	______________________
________ to ________	$________	__________________	Name____________________	______________________
		__________________	Tax ID __________________	______________________

IF YOUR PROVIDER DOES NOT SIGN THE CLAIM FORM YOU MUST SUBMIT INDEPENDENT, 3RD PARTY DOCUMENTATION OF THE EXPENSES WITH THIS CLAIM FORM. PLEASE ATTACH A STATEMENT OF YOUR ACCOUNT, A BILL OR A RECEIPT FROM YOUR PROVIDER.

I certify that the services described on this claim form were necessary for my employment or the employment or education of my spouse. The services were provided for my qualified dependents. I further certify that the dates and fees are true and that I have not sought reimbursement elsewhere for these expenses.

Signature (required): ____ Date: ________________________

☐ Check here if your address has changed. New address: ____

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FILING A CLAIM

- Eligible dependents are:
  - Your children that live with you and are under thirteen (13) years of age; or
  - Your tax dependents incapable of self-care that reside in your home at least eight (8) hours per day.
- A flexible benefits dependent care account is available to you and your spouse if necessary for you both to remain gainfully employed or for you to remain gainfully employed while your spouse maintains full-time student status. A dependent care account is also available to single parents.
- The care can be provided through babysitters, live-in care, and/or licensed day care centers.

Ineligible expenses are:

- Expenses paid for care to your spouse or one of your children under the age of nineteen (19).
- Schooling expenses for the kindergarten level and above.
- Overnight camp.
- Nursing homes.
- Meals or other expenses billed separately.
- Transportation from any source other than the provider.

You may attach a bill or a receipt from your provider to this claim form or simply have your provider sign the front of this form on the appropriate line(s).

Eligible claims received must total at least $1.00 before a check will be mailed or an electronic deposit initiated by Allegiance.

Save time! Direct deposit is a convenient and easy way to receive your flex reimbursement - see www.allegianceflexadvantage.com and sign up today!