

Attn: FSA Department  
P.O. Box 5689  
Irvine, CA 92616  
Phone: 888.289.4062 • Fax: 800.930.0437  
E-mail: [fsa@proviewbenefits.com](mailto:fsa@proviewbenefits.com)  
[www.proviewbenefits.com/login/](http://www.proviewbenefits.com/login/)

**INSTRUCTIONS:**

- Complete **ALL SECTIONS** of this form to ensure timely payment.
- Submit the following documentation with your Dependent Care request:
  - The receipt or bill for the services rendered containing all of the following information:
    - The name of the person(s) for whom services were rendered
    - The provider's name and tax identification number (TIN)
    - The date range the services were rendered

**NOTE:**

- Cancelled checks, credit card receipts, or balance due statements are NOT sufficient.
- Prepaid services cannot be reimbursed in advance. Any claims submitted for prepaid services will be prorated and paid as services occur.
- You may send claims via any one of the following options: fax, e-mail, postal mail, or by logging onto your account at [www.proviewbenefits.com/login/](http://www.proviewbenefits.com/login/).  
If faxing your claim, please indicate the number of pages included. Faxed claims must be legible for processing. **# OF FAXED PAGES = \_\_\_\_\_**.  
If sending claims via e-mail, note that there is a 3MB size limit to e-mail attachments.

**PART A: YOUR INFORMATION**

EMPLOYER NAME			
EMPLOYEE NAME (First, Middle, Last)			SOCIAL SECURITY NUMBER (optional)
STREET ADDRESS		CITY	STATE ZIP
<input type="checkbox"/> NEW ADDRESS			
DAYTIME PHONE NUMBER (with area code) ( ) -	EVENING PHONE NUMBER (with area code) ( ) -	E-MAIL ADDRESS	

**PART B: REIMBURSEMENT REQUEST**

DATE(S) OF SERVICES RECEIVED	AMOUNT YOU PAID \$		
DESCRIPTION OF SERVICES RECEIVED			
DEPENDENT NAME	AGE:	BIRTHDATE / /	RELATIONSHIP TO YOU
DEPENDENT NAME	AGE:	BIRTHDATE / /	RELATIONSHIP TO YOU

Claims **MUST** be received by 12 Noon (PST) Wednesday to be considered for reimbursement on Friday.

**PART C: PROVIDER CERTIFICATION**

NAME OF SERVICE PROVIDER	TAX IDENTIFICATION NUMBER (TIN) / SOCIAL SECURITY NUMBER	SERVICE PROVIDER'S SIGNATURE (if no receipt is given)
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**PART D: EMPLOYEE STATEMENT**

To the best of my knowledge and belief, my statements in this request for Dependent Care Reimbursement are complete and true. I am claiming reimbursement only for eligible Dependent Care expenses during the applicable Plan Year and for eligible Plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my Dependent Care Reimbursement Account to be reduced by the amount requested.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date