Dependent Care FSA Documentation

Name _____

Mailing Address _____

City, State, ZIP _____ Is this a new address? **Yes** **No**

Daytime Phone Number _____ Email Address _____

Dependent Name _____ Dependent Age _____

Provider Name _____ Federal Tax ID _____

Provider Address _____

Payment Amount **$** _____ Service Start Date _____

Number of Payments _____ Service End Date _____

Total Paid to Provider **$** _____

Note: You can claim the total expenses you plan to pay this plan year with appropriate documentation.

Submit this form and documentation to:

Fax (904) 880-2830

Mail BenefitsWorkshop
P.O. Box 56828
Jacksonville, FL 32241

Questions? Contact us!

Email info@benefitsworkshop.com

Phone (888) 537-3539

Website www.benefitsworkshop.com/martincounty

IMPORTANT: Documentation Requirements
Forms must be signed by the participant. All forms must be accompanied by valid receipts or a provider's signature. To claim expenses not yet paid to the provider, either have the provider sign this form or provide a service contract.

By signing below, you certify that the payment amount and service dates are accurate and both the participant and provider will notify BenefitsWorkshop if circumstances alter the payment amounts and/or dates of service.

_____ _____
Provider Signature Date

_____ _____
Participant Signature Date