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MESSA

1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
800.890.0393
Fax: 517.333.6258

OptionALL

Dependent Care Spending Account Plan
Withdrawal Request

Part 1 EMPLOYEE INFORMATION (Please Print)

Employee Name (Last, First and Mi):	Employee Date of Birth	Employee Soc. Sec. No.

Employee Address	City	State	Zip Code	Daytime Telephone No.

Employer Name	Department/Location

Part 2 DESCRIPTION OF EXPENSES AND WITHDRAWAL AMOUNT REQUEST
(Please place <u>each</u> expense on a separate line.)

Dependent Name	Relationship	Birthday	Dates When Care Was Rendered From	To	Names and Addresses of Provider/Facility*	Day Care Provider Tax ID or Soc. Sec. #	Withdrawal Request Amount
					Total Request for Withdrawal	**$**	

Part 3 EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I request reimbursement of the attached expenses under my dependent care reimbursement account plan. I certify that these expenses are for dependent care as defined by the Internal Revenue Code (see reverse for requirements). Furthermore, I declare that these expenses have been incurred by me and have not been reimbursed from any other source nor do I expect them to be. I will notify my employer in the event they are reimbursed.

Any person who knowingly and with intent to injure, defraud or deceive any benefit plan, files a statement or claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

EMPLOYEE SIGNATURE: _____ DATE: _____

SEE INSTRUCTIONS ON REVERSE SIDE →

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EMPLOYEE INSTRUCTIONS

Please read these instructions before completing the FSA Withdrawal Request on the front of this form.

1. Complete all areas of Part 1 “Employee Information.” Complete Part 2 “Description of Expenses and Withdrawal Amount Request.”
2. Read Part 3 “Employee’s Certification for Reimbursement” statement; then sign and date the form where indicated.
3. For each eligible dependent care expense not covered by any benefit plan, attach a copy of the itemized receipt to this form. Reimbursement amounts should be submitted as they are incurred, but payment will be made only after they total $20 or more.
4. Make a copy of this form and all attached receipts for your records (optional).
5. Mail or fax this form and dependent care receipts to:

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AN IMPORTANT REMINDER

We have made the withdrawal request administrative process as simple as possible, but we remind you of the following important points:

- You must use this form to request all FSA reimbursements.
- Reimbursement dollars are paid to you. They may not be paid to any other person.
- You must attach any itemized receipts to each withdrawal request form you submit.
- Cancelled checks and non-itemized receipts are not acceptable for proof of expense.
- Incomplete requests will be returned to you for the additional information. They will not be processed until all information is provided.
- Federal law requires that any unused account balance remaining at the end of the plan year be forfeited.

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