

# DEPENDENT CARE ACCOUNT REIMBURSEMENT REQUEST FORM

**CONTACT:**

NORTH AMERICAN  
ADMINISTRATORS, INC.  
1-866-448-1696  
FLEXIBLE SPENDING ACCOUNTS

## DEPENDENT CARE ACCOUNT REIMBURSEMENT REQUEST FORM

**SUBMIT CLAIMS TO:**

NORTH AMERICAN ADMINISTRATORS, INC.  
PO BOX 926  
AMHERST, NEW YORK 14226-0926  
OR FAX TO 1-716-319-5575

### PERSONAL INFORMATION

Employer	For Plan Year	Social Security Number
Employee Name (Last) (First) (Initial)		Telephone Number
Home Address Street City State Zip		

### SUMMARY OF DEPENDENT CARE EXPENSE

NAME OF EMPLOYEE DEPENDENT RECEIVING SERVICE	RELATIONSHIP TO EMPLOYEE	PROVIDER OF SERVICE	DATES OF SERVICE		AMOUNT TO BE REIMBURSED
			FROM	TO	

**TOTAL AMOUNT** \_\_\_\_\_

### AUTHORIZATION

I certify that, to the best of my knowledge, the above information is accurate and that reimbursement is being requested only for expenses of eligible dependents. I am requesting reimbursement only for eligible expenses as defined in the summary plan description that have not and will not be paid under any other benefit plan or claimed as a credit on my Federal income tax return. I authorize North American Administrators on behalf of my employer to reimburse me for the total amount requested from my Dependent Care Account.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Please review this form carefully. Forms improperly completed will be returned and may result in a delay in your reimbursements.