



# Dependent Care FSA Documentation

Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Employer \_\_\_\_\_  
 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

**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