GIVENS ESTATES, INC.

Flexible Spending Account (FSA)

Dependent Care Reimbursement Form

1200 Ridgefield Blvd, Suite 215
Asheville, NC 28806
Phone – (828) 670-9145
Fax – (828) 670-9155
Email –givens.flex@crescenths.com

SECTION (I) PERSONAL INFORMATION

Last Name	First Name	Middle Name
Member ID	**Department/Division**	**Work Phone Number**

SECTION (II) DEPENDENT CARE EXPENSE INFORMATION

Item No.	Date of Expense From	Through	Provider of Services	Provider's Social Security or Tax Identification Number	Name of Your Dependent(s)	Eligible Amount of Expenses
1						$
2						$
3						$
4						$
5						$
6						$
					Total of Eligible Expenses	$

SECTION (III) EXPENSE CERTIFICATION

In order to certify the expenses above, please do either one of the following:

1) Staple invoices including date(s) of service,
OR
2) Have the Dependent Care Provider verify the information by signing below.

Signature of Service Provider I provided dependent care services for the above named individual. I certify that the information provided above is correct.	**Date of Signature**

SECTION (IV) EMPLOYEE AUTHORIZATION AND SIGNATURE

By my signature below, I request payment from my Dependent Care Flexible Spending Account for the itemized expenses listed above or attached to this form. By my signature below, I certify the following:

1) I have not been reimbursed under this FSA Plan or from any other source for these expenses;
2) I have met all of the requirements for eligible dependent care expenses as described in the FSA Plan Document and other FSA materials;
3) The services claimed above were received during the current plan year and while I was an active participant in the Plan;
4) The total dependent care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lessor of my or my spouse's earned income for the year. I understand that reimbursed expenses cannot be claimed as deductions on my personal income tax return. I understand that according to IRS rules, any account balances as of March 31st following the end of the calendar year will be forfeited.

APPLICANT SIGNATURE	DATE

To submit a claim, please remit this form and any attachments to:

Via Email	Via Fax	Via US Mail
givens.flex@crescenths.com	1-828-670-9155	Crescent Health Solutions ATTN: FSA Claims 1200 Ridgefield Blvd, Suite 215 Asheville, NC 28806