AMERICAN FIDELITY
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DEPENDENT DAY CARE REIMBURSEMENT / PROVIDER ACKNOWLEDGEMENT FORM

Name of Employee (Last, First, MI)	**Social Security #**
Mailing Address ☐ *Check here if this is a new address; if so, do you have other AF products?*	**E-mail address**
Name of Employer	**Daytime Phone #**

You will receive notification by e-mail when your claim is received and another when a payment is sent. You will also receive e-mail notification of direct deposits. Please be sure your e-mail address is legible.

It is hereby acknowledged by _____ (the "Dependent Day Care Provider") that it is in compliance with any and all applicable federal, state, and local regulations governing dependent day care centers. The Dependent Day Care Provider further acknowledges that it has received $_____ from _____ (Employee's Name/"Participant") for dependent day care services incurred for the period of _____ through _____ for the following individuals:

Name	**Age**

Please provide the following required information for Dependent Day Care Reimbursement:

_____ Name of dependent day care center or individual provider

_____ Tax I.D. number of day care center, or social security number of individual provider.

_____ Address of dependent day care center or individual provider

_____ Date _____ Signature of dependent day care center representative or individual provider

I authorize the above claimed expenses to be reimbursed from my account and certify that to the best of my knowledge and belief all information stated on this form is true and correct. I further certify that 1) the total reimbursements to date (including the amount requested) do not exceed the lesser of $5,000 or $2,500 (as applicable), my earned income, spouse's earned income, or my employer's set maximum; 2) neither the Dependent Care Tax Credit nor any other federal income tax credit or deduction will be claimed for the amount requested and reimbursement will not be sought from any other plan coverage; and 3) the daycare services giving rise to the expense for which reimbursement is requested have already been provided.

_____
Signature of Employee

_____
Date Signed

MAILING ADDRESS:
American Fidelity Assurance Company Flex Account Administration
P.O. Box 161968
Altamonte Springs, FL 32716

FAX NUMBER: 844-319-3668 PHONE NUMBER: **800-662-1113**
(We are unable to verify receipt of your fax for 1 full business day after it was sent)

Who is a Qualifying Dependent for Dependent Day Care Plans?

- Your tax dependent as defined in Internal Revenue Code Section 152(a)(1) (i.e. a qualifying child) who has not reached the age of 13 and has the same principal place of abode as you for more than one-half of the year.
- Your tax dependent as defined in Internal Revenue Code Section 152(a)(1) or (2) (i.e., a qualifying child or qualifying relative) who is physically or mentally incapable of self-care and who has the same principal place of abode as you for more than half of the year. The individual must spend at least eight hours per day in your household.
- A spouse who is physically or mentally incapable self-care and who has the same principle place of abode as you for more than one-half of the year. The individual must regularly spend at least eight hours per day in your household.

Average processing time is 5 to 7 working days from receipt of a completed voucher. Processing times may vary throughout the year.
American Fidelity will not be responsible for faxes not received.