Recurring DCA Claim Form

▶ You can submit this data via **myameriflex**

INSTRUCTIONS: Please read carefully and be sure your claim is completed in its entirety to ensure there is no delay in processing. Please do not use a highlighter on claim form, receipts, or any documents included as backup as this may cause a delay in processing your claim. All approved claims submitted via this form will be paid directly to the Participant. To submit a claim to pay a Provider directly, please visit the Ameriflex Participant Portal.

1) Complete all applicable sections, sign and date.
2) Upload the completed claim form in the Participant Portal or email the form to Ameriflex.
3) Please allow 2-3 business days for claims processing from the date the claim is received.
    a) Direct Deposit: 3-5 business days from the date the claim is processed.
    b) Check Delivery: 7-10 business days from the date the claim is processed
4) Please submit one claim form per plan year.

Dependent Day Care Expenses: When you have recurring dependent day care expenses, you can get recurring reimbursement without having to file a claim after each date of service. To set up a recurring claim, you must provide the date range of services that will be provided, a signature from your provider verifying the requested expenses will be incurred, and the tax ID number for the provider. If you are using a private provider (i.e. babysitter), their SSN can be used in place of the Tax ID number.

To avoid delays in reimbursement, please sign and date this claim form and provide notice of any name or address change to Ameriflex.

I authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year. I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source, and will not be claimed as an income tax deduction. I also understand that I may be asked to provide further details (i.e. a letter of medical necessity from a medical practitioner certifying that the expense is to treat or cure a medical condition or a more detailed certification from me). I understand that if my claim is for expenses incurred during a Grace Period: (**1**) the expenses will be reimbursed first from available amounts remaining at the end of the preceding Plan Year and then during the Current Plan Year; (**2**) claims are paid in the order in which they are approved; and (**3**) once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.

Ameriflex

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Step 1 Employer Name:

Employee Name: SSN:

Phone: Email:

Step 2 Dependent Day Care Claims

Dependent Name	Dependent Date of Birth	Date of Service From	To	Provider Name	Provider Tax ID #	Type of Service (Day Care, Pre-K, Day Camp, etc.)	Amount Requested

Provider Signature or Stamp - REQUIRED

STEP 3 **Form cannot be processed without valid signature**

By signing this document I agree to the terms and conditions detailed in the instructions provided on page one.

Employee Signature **Date**

Please email, fax, or mail to:

Email	Fax	Mail
claims@myameriflex.com	888.631.1038 Attention: Claims Department	**Ameriflex Claims Department** P.O. Box 269009 Plano, TX 75026 *Please do not send original documents. If damaged or lost during processing, they cannot be replaced.*