how to:

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Complete the Dependent Daycare Reimbursement Form

Dependent Care Reimbursement Forms are completed with the participant's actual expense information. These expenses must be verifiable by payment receipts from the dependent care provider in the event of a plan audit. It is very important that the expenses not be averaged out over the year as is done to calculate the deduction amount.

In the example given, the actual expense is $200 monthly from January through May, then decreases to $0 during the summer months, and returns to $200 monthly from September thru December. The total annual expense is $1,800, which is the amount that should be entered on the enrollment form. If the participant is paid monthly, that amount would be entered on the enrollment form. If the participant is paid monthly, that amount would be divided by 12 to arrive at the payroll deduction amount of $150 per pay period. However, the claim reimbursement would be calculated based on the actual expense amount. If the expense amount is less than the deduction amount, a fund balance accumulates that is used to pay on the higher expenses later in the year. Any unprocessed claim amounts accumulate in a claim balance, which in turn are then paid by any excess funds, as follows in this EXAMPLE:

Month	Deduction	Expense	Payment	Fund	Claim Balance
January	$150	$200	$150	$0	$50
February	$150	$200	$150	$0	$100
March	$150	$200	$150	$0	$150
April	$150	$200	$150	$0	$200
May	$150	$200	$150	$0	$250
June	$150	$0	$150	$0	$100
July	$150	$0	$100	$50	$0
August	$150	$0	$0	$200	$0
September	$150	$200	$200	$150	$0
October	$150	$200	$200	$100	$0
November	$150	$200	$200	$50	$0
December	$150	$200	$200	$0	$0

*** It is very important that the enrollment form reflect the exact annual amount calculated on the Reimbursement Form. Any deviation will result in over contributions and the loss of the participant's money at the end of the plan year.***

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Dependent Day Care Claim Form

First Financial Administrators, Inc.

EMPLOYEE INFORMATION (Please Print)

EMPLOYER	FIRST NAME	MI	LAST NAME
ADDRESS	CITY	STATE	ZIP
PHONE (Between Hours of 8am-5pm)	SSN	EMAIL ADDRESS	

DEPENDENT DAY CARE EXPENSES

Dependent day care expenses must be for a dependent who is incapable of self-care or under the age of 13 at the time the care was provided.

NAME OF DEPENDENT	AGE	DATES CARE PROVIDED FROM	DATES CARE PROVIDED TO	NAME, ADDRESS, AND SSN/TAXPAYER ID # OF CARE PROVIDER	COST FOR CARE PERIOD	FFG USE ONLY
				TOTAL DEPENDENT CARE AMOUNT REQUESTED	0	

PROVIDER SIGNATURE (Required if an itemized receipt is not attached.)

I provided the dependent care as stated above.
CARE PROVIDERS ORIGINAL SIGNATURE:_____ DATE:

EMPLOYEE SIGNATURE (REQUIRED)

I certify that I have incurred the Dependent Day Care expense for me to work or look for work, and if married, my spouse to work or look for work. These expenses are for a Qualifying Person. These expenses are not for educational purposes to attend kindergarten or higher. I acknowledge that I will have to report the caregiver's name, address, and Tax Identification Number on Form 2441.
I understand that I cannot be reimbursed until the expense has been incurred; no prepayments. I cannot be reimbursed until the funds have been received by my employer and deposited in my account.
Note: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for insufficient funds. Please contact your financial institution to verify deposit.
EMPLOYEE SIGNATURE:_____ DATE:

See page 2 for claim filing guidelines.

CONTACT US TODAY:
PO Box 161968, Altamonte Springs, FL 32716 | Online: *www.ffga.com* | Phone: 866-853-FLEX
Fax number: 800-298-7785 | Tech Support: techsupport@ffga.com
Flex Receipts and Documents only: First_Financial_Receipts@Alegeus.com

First Financial Administrators, Inc.
PO Box 161968 · Altamonte Springs, FL 32716
Phone: 866-853-3539 · Fax: 800-298-7785

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SUBMISSION GUIDELINES

Please follow these guidelines to ensure that your claims are reimbursed quickly.

Acceptable Documentation:

- Itemized statement which includes:
- Provider Name
- Qualifying Person's Name
- Date of Service
- Amount Charged for the Care Services
- Tax Identification Number/Social Security Number of Provider

Unacceptable Documentation:

- Canceled checks
- Debit card or credit card receipts

Claims for future services are not eligible for reimbursement.

Mail Claim Forms to:

First Financial Group of America
FSA Department
PO Box 161968
Altamonte Springs, FL 32716

Fax Claim Forms to:

800-298-7785

Email Claim Forms to:

First_Financial_Receipts@Alegeus.com

Fill out a claim form online:

www.ffga.com

Complete your claim form online and upload documentation on our secure participant portal by logging into www.ffga.com.

FF Flex Mobile App:

File a claim form on your mobile device using the FF Flex Mobile App. Available for download on the App Store or Google Play Store for Apple and Android devices.

Visit www.ffga.com for more information about Flexible Spending Accounts.

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