

# COVID-19 Claim Form for Prior Year Funds



Use this form to manually claim for reimbursement of dependent care expenses for a plan year which the run-off period has expired on or after 12/31/2019. You must have incurred the expenses out-of-pocket and have not been reimbursed from any other source.

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

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)
<p>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.</p> <p>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.</p> <p>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.</p> <p>EMPLOYEE SIGNATURE: _____ DATE: _____</p>

### CONTACT US TODAY:

PO Box 161968, Altamonte Springs, FL 32716 | Online: [www.ffga.com](http://www.ffga.com) | Phone: 866-853-FLEX  
 Fax number: 800-298-7785 | Tech Support: [techsupport@ffga.com](mailto:techsupport@ffga.com)  
 Flex Receipts and Documents only: [First\\_Financial\\_Receipts@Alegeus.com](mailto:First_Financial_Receipts@Alegeus.com)

## 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](http://www.ffga.com)

Complete your claim form online and upload documentation on our secure participant portal by logging into [www.ffga.com](http://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](http://www.ffga.com) for more information about Flexible Spending Accounts.