

Dependent Care Reimbursement



Submit completed form online: (1) Log in at goHealthInvest.com; (2) Click the envelope icon (✉) to send as an attachment via secure messaging. Or, **mail to:** Gallagher HealthInvest FSA, PO Box 4390, Clinton, IA 52733-4390. **Questions?** Call 1-844-342-5505.



1 Participant Information

Participant Number or SSN: _____ Date of Birth: _____

Name: _____

Address: _____ Check if new address

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Direct Deposit Information

Bank Name: _____ Account type: Checking Savings

Routing Number: _____ Account Number: _____

2 Reimbursement Details

- Complete this entire Reimbursement Details section and include supporting documentation, if applicable.
- Use a separate form for each request.
- Supporting documentation must contain all of the following: provider name and Tax ID number or Social Security number; dependent name; date(s) of service; and amount.
- If no supporting documentation is provided, the provider must certify the expense by signing below.

Reimbursement Details

Provider Information	Dependent Information	Reimbursement Information
Provider Name: _____ Tax ID/SSN: _____ Signature of Provider: (Replaces the need for documentation of service.) _____	Name: _____ DOB: _____ SSN: _____ Relationship to Participant: <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other	Date of Service: _____ to _____ Amount: _____ Type of Care: <input type="radio"/> Adult Day Care <input type="radio"/> Au Pair <input type="radio"/> Babysitter <input type="radio"/> Before/After school <input type="radio"/> Child Care <input type="radio"/> Family Care Provider <input type="radio"/> Home Aide <input type="radio"/> Preschool <input type="radio"/> Summer Day Camp <input type="radio"/> Other

3 Authorization (signature required to process reimbursement)

By signing and submitting this form, I acknowledge and certify: (1) The information being submitted is accurate and complete to the best of my knowledge; (2) The expense listed above qualify for reimbursement under applicable IRS regulations and guidance to the best of my knowledge; (3) I am requesting reimbursement of qualified dependent care expenses for my spouse or qualifying dependents; (4) These services have already been provided and the out-of-pocket expense has been incurred; (5) I have not and will not seek reimbursement for these expenses from any other plan or party, and such expenses are not reimbursable from another source; and (6) I understand Gallagher HealthInvest reserves the right to deny a claim or debit card transaction if I have not provided proper substantiation or if there is reason to believe the expense is not qualified as defined in the Summary Plan Description or regulatory guidance, in which case I may be responsible for reimbursing the Plan for such expense. Further, I understand that the reimbursed expense may not be used to claim any federal income tax deduction or credit, such as the Dependent Care Tax Credit. I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification numbers.

Participant Signature: _____ Date: _____