FSA | Flexible Spending Account

Dependent Care Reimbursement

Gallagher | HealthInvest

Skip this form! Submit your claim online.

(1) Log in at **goHealthInvest.com** or through **HRAgo**® (mobile app); (2) Click **Claims**; and (3) Click **Submit a Claim**. Or, mail completed form with copies of supporting documentation to: Gallagher HealthInvest, PO Box 4390, Clinton, IA 52733-4390. For questions, contact us at: **1-844-342-5505.**

FS02

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

1. Complete this entire Reimbursement Details section and include supporting documentation, if applicable.
2. Use a separate form for each request.
3. 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.
4. 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: _____	Name: _____	Date of Service: _____ to _____
Tax ID/SSN: _____	DOB: _____	Amount: _____
Signature of Provider: (Replaces the need for documentation of service.) _____	SSN: _____	Type of Care: ◯ Adult Day Care ◯ Au Pair ◯ Babysitter ◯ Before/After school ◯ Child Care ◯ Family Care Provider ◯ Home Aide ◯ Preschool ◯ Summer Day Camp ◯ Other
	Relationship to Participant: ◯ Spouse ◯ Qualifying Child ◯ Qualifying Relative ◯ 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: _____