RP RILEY MANAGEMENT GROUP

FSA Department
P.O.Box 146
Mukwonago, WI 53149
Toll Free Tel: 888-820-1051 Fax: 262-363-5556
Email- claims@rpriley.com

DEPENDENT CARE ASSISTANCE EXPENSES
REIMBURSEMENT REQUEST FORM

Employer Name	Branch Location		Group No.
Employee's Last Name	First	M.I.	Birth Date(Mo/Day/Yr.)
Street Address	City	State	Zip Code
ID No.	Telephone No.		Sex: ☐ Male ☐ Female

Dependent Care Expenses

Dependent Name(s)	Relationship	Age
1		
2		
3		

Dependent Care Provider Name _____
Street Address _____
City _____ State _____ Zip _____
Tax I.D. or Social Security No. _____

Dates of Care	Amounts
	$
	$
TOTAL AMOUNT REQUESTED	$

Provider's Signature (or attach receipt): _____
Date: _____

Is Provider of Service related to the Dependent? ☐ Yes ☐ No If yes, please list age and relationship of provider.
Age: _____ Relationship: _____

I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or eligible members of my family. In claiming reimbursement for dependent care expenses. I certify that my spouse and I WILL NOT receive reimbursement in excess of $5,000 from all employer sponsored care accounts,

Participant's Signature: _____ Date: _____