

Public Employees Health Programs, FLEX\$ Day Care

560 East 200 South, Suite 100
Salt Lake City, Utah 84102-2004
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**FLEXIBLE REIMBURSEMENT PROGRAM
(FLEX\$)**

**AUTOMATIC REIMBURSEMENT CLAIM
FORM/DIRECT DEPOSIT FORM**

Initial Request Change Request Cancel Request

EMPLOYEE INFORMATION		
EMPLOYEE NAME (last, first, middle initial)	ID#	PLAN YEAR:
HOME ADDRESS	CITY / STATE / ZIP	DAYTIME PHONE

QUALIFIED DEPENDENT DAY CARE EXPENSES:

PROVIDER	PROVIDER TIN/SSN#	DATES OF SERVICE	DEPENDENT NAME	AMOUNT
Claims must be for services performed within the Plan Year.				TOTAL

Requests for automatic reimbursement must include a copy of a written contract, statement or agreement letter from the day care provider. The agreement must show: Provider name, address, Tax ID or Social Security number, and anticipated costs for the Plan Year. **You will be required to provide a statement and/or copies of receipts from your day care provider, at the end of the Plan Year documenting the actual costs incurred.** Employee must submit an Automatic Reimbursement Claim for each plan year.

Funds will be paid to you automatically, as they are received by PEHP from your employer. You will be notified by mail when each deposit has been processed. In order to participate in the Automatic Reimbursement Plan, you must sign up for direct deposit. Failure to maintain a direct deposit account will cancel participation in the Automatic Reimbursement Program.

Participant Agreement: I, the undersigned, hereby certify that the expenses for which reimbursement is sought herein are expenses that I, the participant believe in good faith are qualified Dependent Day Care expenses during the Plan Year. I understand that if any changes in day care providers occur, I will notify PEHP immediately.

EMPLOYEE SIGNATURE	DATE	PEHP APPROVAL
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Unsigned forms will not be processed.

DIRECT DEPOSIT SETUP

EFFECTIVE DATE
(mm/dd/yy)

BANK/C.U. ROUTING #
(9-digit number)

PERSONAL ACCOUNT #
(print your account # as it appears on your check)

Account Type: Checking Savings

I hereby authorize Public Employees Health Program to directly deposit my FLEX\$ Benefit reimbursements to the account identified above and by the attached voided check. I understand that the notice of deposit is not a guarantee that funds have been received by my financial institution. I acknowledge that this authorization is binding and may only be altered or cancelled upon written notification from me to Public Employees Health Program.

EMPLOYEE SIGNATURE	DATE	PEHP APPROVAL
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Unsigned forms will not be processed.

NOTE: Please attach a voided check. Your request for an automatic reimbursement and direct deposit cannot be processed without it.