



**Dependent Care
Recurring Reimbursement Request**
fsa@pbaclaims.com - Email
630-286-4660 – Fax

Send Claims to:
Professional Benefit Administrators, Inc.
P.O. Box 4687
Oak Brook, IL 60522
Phone: (800) 435-5694

☐	Check this box if your address has changed
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Employer Name: _____

Employee Name:	
Address:	
City, State, Zip	
ID Number:	
Daytime Phone Number:	Email Address:

I verify that I make regular, ongoing payments to: *(Required)*

Name of Dependent Care Provider: (Required)	
Name of Dependent:	DOB:
Name of Dependent:	DOB:

The charge for their care is \$ _____ per _____, beginning on ____/____/____. I authorize **Professional Benefit Administrators, Inc.** to automatically reimburse me the amount stated above from my Flexible Spending Dependent Care Account. I understand that the reimbursements will be made only up to the cash balance of my Flexible Spending Account. Unpaid claims are reimbursed as more money is credited to my account. Any unused funds remaining in the account at the end of the plan year will be forfeited.

I agree that if the amount changes or if, for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will notify **Professional Benefit Administrators, Inc.** immediately in writing.

This form is only valid for the current plan year.

Signed _____ Date _____
Employee

Provider Verification

I verify that the above charges are accurate as described.		
_____ Provider Signature	_____ Federal Tax ID Number	_____ Date

Please note: The dependent care provider must declare this as income on their tax return.

**WOULD YOU LIKE TO RECEIVE ALL FUTURE REIMBURSEMENTS FASTER?
SIGN UP FOR DIRECT DEPOSIT TODAY!**

Simply login to your account at www.pbaclaims.com, click on View FSA / HRA / HSA and then "Tools & Support". Under the "How Do I?" section, you will see an option to change your payment method. After just a few quick clicks and entering your bank information, you will be set up to receive all future reimbursements via direct deposit.