



**OptionALL**  
Dependent Care Spending Account Plan  
Withdrawal Request

Part 1 EMPLOYEE INFORMATION (Please Print)						
Employee Name (Last, First and Mi):			Employee Date of Birth		Employee Soc. Sec. No.	
Employee Address			City	State	Zip Code	Daytime Telephone No.
Employer Name				Department/Location		

Part 2 DESCRIPTION OF EXPENSES AND WITHDRAWAL AMOUNT REQUEST (Please place <u>each</u> expense on a separate line.)							
Dependent Name	Relationship	Birthday	Dates When Care Was Rendered		Names and Addresses of Provider/Facility*	Day Care Provider Tax ID or Soc. Sec. #	Withdrawal Request Amount
			From	To			
<b>Total Request for Withdrawal</b>						<b>\$</b>	

Part 3 EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT	
<p>I request reimbursement of the attached expenses under my dependent care reimbursement account plan. I certify that these expenses are for dependent care as defined by the Internal Revenue Code (see reverse for requirements). Furthermore, I declare that these expenses have been incurred by me and have not been reimbursed from any other source nor do I expect them to be. I will notify my employer in the event they are reimbursed.</p>	
<p><b><i>Any person who knowingly and with intent to injure, defraud or deceive any benefit plan, files a statement or claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.</i></b></p>	
<p>EMPLOYEE SIGNATURE: _____ DATE: _____</p>	



## EMPLOYEE INSTRUCTIONS

***Please read these instructions before completing the FSA Withdrawal Request on the front of this form.***

1. Complete all areas of Part 1 "Employee Information." Complete Part 2 "Description of Expenses and Withdrawal Amount Request."
2. Read Part 3 "Employee's Certification for Reimbursement" statement; then sign and date the form where indicated.
3. For each eligible dependent care expense not covered by any benefit plan, attach a copy of the itemized receipt to this form. Reimbursement amounts should be submitted as they are incurred, but payment will be made only after they total \$20 or more.
4. Make a copy of this form and all attached receipts for your records (optional).
5. Mail this form and dependent care receipts to:

MESSA  
1475 Kendale Blvd., P.O. Box 2560  
East Lansing, MI 48826-2560

## AN IMPORTANT REMINDER

We have made the withdrawal request administrative process as simple as possible, but we remind you of the following important points:

- You must use this form to request all FSA reimbursements.
- Reimbursement dollars are paid to you. They may not be paid to any other person.
- You must attach any itemized receipts to each withdrawal request form you submit.
- Cancelled checks and non-itemized receipts are not acceptable for proof of expense.
- Incomplete requests will be returned to you for the additional information. They will not be processed until all information is provided.
- Federal law requires that any unused account balance remaining at the end of the plan year be forfeited.



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