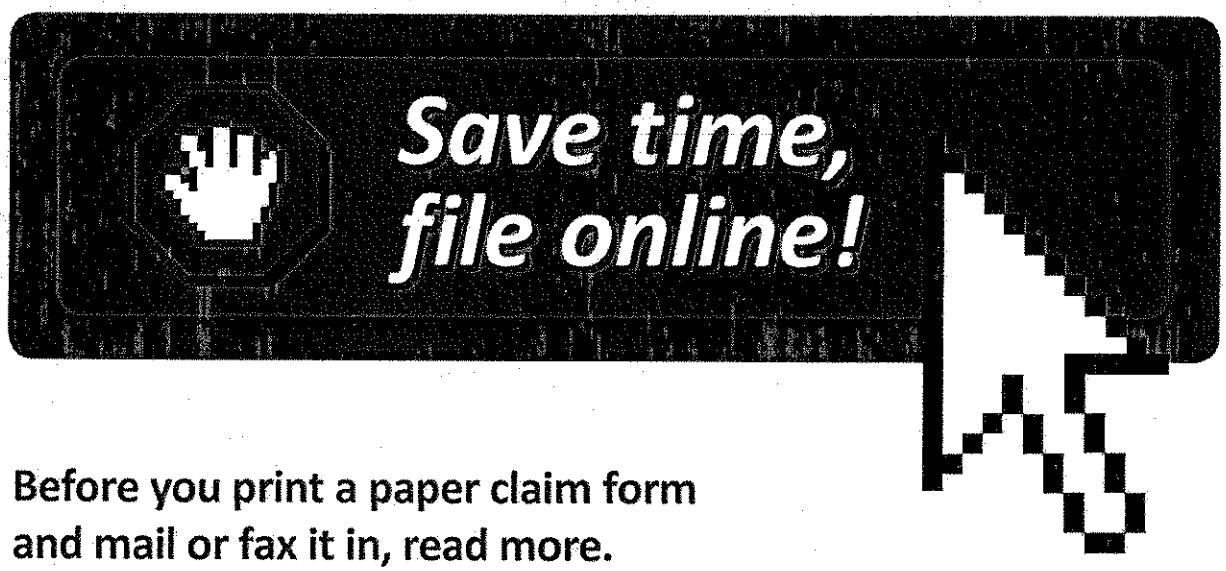
DDC



Before you print a paper claim form and mail or fax it in, read more.

Dependent Daycare Flexible Spending Account participants may now file claims electronically through the Online Service Center with a secured online account. Three easy steps for filing your claim online:

1. Login to your secured online service center account. If you don't have one, you can sign up at the login screen.
2. Submit a new claim, forward substantiation for a debit card swipe, sign up for direct deposit, and review claim history and account balance.
3. Check your claim status. Claims are processed within the standard turnaround time.

Still prefer to file a paper claim? Scroll down to the claim form below.

DEPENDENT DAY CARE REIMBURSEMENT / PROVIDER ACKNOWLEDGEMENT FORM

Name of Employee (Last, First, MI)	Social Security #

Mailing Address	E-mail address
☐ *Check here if this is a new address; if so, do you have other AF products?*	

Name of Employer	Daytime Phone #

*** You will receive notification by e-mail when your claim is received and another when a payment is sent. You will also receive e-mail notification of direct deposits. Please be sure your e-mail address is legible.***

It is hereby acknowledged by _____ (the "Dependent Day Care Provider") that it is in compliance with any and all applicable federal, state, and local regulations governing dependent day care centers. The Dependent Day Care Provider further acknowledges that it has received $_____ from _____ (Employee's Name/"Participant") for dependent day care services incurred for the period of _____ through _____ for the following individuals:

Name	Age

Please provide the following required information for Dependent Day Care Reimbursement:

_____ Name of dependent day care center or individual provider

_____ Tax I.D. number of dependent day care center, or social security number of individual provider

_____ Address of dependent day care center or individual provider

_____ Date _____ Signature of dependent day care center representative or individual provider

I authorize the above claimed expenses to be reimbursed from my account and certify that to the best of my knowledge and belief all information stated on this form is true and correct. I further certify that 1) the total reimbursements to date (including the amount requested) do not exceed the lesser of $5,000 or $2,500 (as applicable), my earned income, spouse's earned income, or my employer's set maximum; 2) neither the Dependent Care Tax Credit nor any other federal income tax credit or deduction will be claimed for the amount requested and reimbursement will not be sought from any other plan coverage; and 3) the daycare services giving rise to the expense for which reimbursement is requested have already been provided.

_____ **Signature of Employee**

_____ **Date Signed**

Who is a Qualifying Dependent for Dependent Day Care Plans?

- Your tax dependent as defined in Internal Revenue Code Section 152(a)(1) (i.e., a qualifying child) who has not reached the age of 13 and has the same principle place of abode as you for more than one-half of the year.
- Your tax dependent as defined in Internal Revenue Code Section 152(a)(1) or (2) (i.e., a qualifying child or qualifying relative) who is physically or mentally incapable of self-care and who has the same principle place of abode as you for more than half of the year. The individual must spend at least eight hours per day in your household.
- A spouse who is physically or mentally incapable self-care and who has the same principle place of abode as you for more than one-half of the year. The individual must regularly spend at least eight hours per day in your household.

FAX NUMBER: 1-800-543-3539
PHONE NUMBER: 1-800-325-0654
(We are unable to verify receipt of your fax for 1 full business day after it was sent)

MAILING ADDRESS:
American Fidelity Assurance Company
Flex Account Administration
P.O. Box 25510
Oklahoma City, OK 73125

Average processing time is 5 to 7 working days from receipt of a completed voucher. Processing times may vary throughout the year.
American Fidelity will not be responsible for faxes not received.

Visit americanfidelity.com for more details on qualifying dependents and to access additional claim forms.

REQUEST FOR
TESTING BENEFITS

American Fidelity Assurance Company
A member of the American Fidelity Group

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.afadvantage.com

INSTRUCTION TO INSURED

1. Complete **STATEMENT OF INSURED.**
2. This form is only to be used for Cancer Diagnostic Benefit, Accident Only Wellness Benefit, and Critical Illness Health Screening Benefit. Please mark all that apply.
3. Please attach **bill, receipt, or evidence of the test.** Submitted evidence must include the name of the test and the date of service.
4. **Be sure to include your account number or Social Security number on all documents.**
5. Fax or mail the completed claim form.

STATEMENT OF INSURED

1. INSURED FULL NAME_____ Account No. _____
(Please Print) (Last) (First) (M.I)

Date of Birth ____/____/____ Insured Social Sec. # _____-_____-_____ Telephone # _____
(MO) (Day) (YR)

2. Address _____
(Street) (City) (State) (Zip Code)

3. If claim is for dependent, give name of dependent_____ Relationship_____

Date of Birth ____/____/____
(Mo) (Day) (YR)

☐ Cancer Diagnostic Benefit ☐ Accident Only Wellness Benefit ☐ Critical Illness Health Screening Benefit

DIRECT DEPOSIT AUTHORIZATION

Please complete if you desire benefits deposited directly into your bank account.

I authorize AFAC to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it. **This authorization applies to benefits payable under all insurance policies held with AFAC.**

Signature: _____
NOTE: You must attach a voided check to begin direct deposit.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

California - For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DE, ID, IN, MN, OH, and OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be guilty of insurance fraud.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona - For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Florida - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii - *For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.*