Group Dynamic Inc.
EMPLOYEE BENEFITS ADMINISTRATION

Automatic Dependent Care Reimbursement Process

The Automatic Dependent Care Reimbursement Process is a great way to save time and paperwork. This process will allow you to submit one claim for the entire plan year and receive reimbursement as payroll deposits are posted.

To qualify for this service, you must meet the following criteria:

- You incur consistent dependent care expenses throughout the plan year;
- You use the same dependent care provider throughout the plan year;
- You are able to obtain a statement or signature from your dependent care provider in advance of the services.

Tips to Avoid Denied Claims:

- *Please do not submit your reimbursement requests prior to the start of the plan year. Although you may have pre-paid for your dependent care services, IRS regulations prohibit reimbursement until after the service has been rendered.*
- *Be sure to include your provider's tax ID number, Social Security Number or tax-exempt status.*

If you meet the criteria listed above and would like to take advantage of the Automatic Dependent Care Reimbursement process, please complete a **Reimbursement Request Form for Flexible Spending Accounts**, then attach the appropriate statement or receipt from your dependent care provider and submit it to:

Group Dynamic, Inc. Reimbursement Team

Email Claims to: claims@gdynamic.com
Fax Claims to: **(207) 518-5200**
Mailing Address: **411 U.S. Route One, Falmouth, ME 04105**

We encourage you to ask questions if you are unsure about this option or if you would like additional information. Please call 207-781-8800 or 1-800-626-3539 and ask for the Reimbursement Team.

Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

REIMBURSEMENT REQUEST

(Please staple receipts to back of form)

EMPLOYEE INFORMATION (Print clearly)	
Employee Name:	Bates ID #:
Employer:	Plan Year:

DEPENDENT CARE (Child Care, Elder Care)					
Provider Name	Provider SS# or Tax ID#	Services For (Name)	Relationship/Age	Service Dates	Amount
				TOTAL:	

DEPENDENT CARE PROVIDER (If you don't have a receipt, this section must be completed)

Provider's Name _____ Provider SS/Tax ID#: _____

Provider's Address _____

Address City State Zip

I certify that I have provided the services as listed above:

_____ _____

Provider's Signature Date

MEDICAL CARE (You may copy form if needed for additional expenses or attach an itemized list)				
Provider Name	Service/Item Purchased	Services For (Name/Relationship)	Date of Service	Amount
Mileage Reminder	You are eligible to reimbursed for mileage to and from an eligible medical appointment.		Number of miles x $0.19 =	
			TOTAL:	

I request reimbursement for my dependent care expenses and/or medical care as itemized above. Enclosed are receipts which state: date of service, provider name, type of service, and fee charged for the service. My signature below acknowledges my understanding of the following: 1.) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source. 2) The expenses must qualify for reimbursement under the Internal Revenue Code. 3) Reimbursed expenses cannot be claimed as credits or deductions on my personal income tax. 4) Participation in a Medical FSA may disqualify me and/or my spouse from participation in a Health Savings Account. 5) I have retained copies of the documentation submitted with this expense as these materials will not be returned to me.

Signature: **Date:**

SIGNATURE REQUIRED

Reimbursement requests must be received before 12 Noon (ET) on Tuesdays for processing that week. Requests received after this time will be processed the following week.

MAIL TO: Group Dynamic, Inc., Reimbursement Benefits, 411 U.S. Route One, Falmouth, ME 04105
EMAIL TO: claims@gdynamic.com WEBSITE: www.gdynamic.com

FAX TO: Reimbursement Benefits, 207-781-5200 PHONE: (207) 781-8800 or 1-800-626-3539

2017