

CRIDER INSURANCE SERVICES, INC.

THIRD PARTY ADMINISTRATORS

7755 Bellaire Drive South Suite C Fort Worth, TX 76132

Mailing address: P.O. Box 34507 Fort Worth, TX 76132

817-735-8304 817-735-8301 (FAX) 1-800-466-2324 (TOLL FREE) email: criderins@aol.com

How to file a Dependent Care Reimbursement Claim

As a participant in your employer's Dependent Care Account, you have three options for filing a claim with Crider Insurance Services, Inc. (CIS).

Each option requires completion of the attached Dependent Care Expense Claim Form and the attachment of receipts from your daycare provider.

OPTION ONE

You may mail the forms and receipts to our office at the address shown above.

OPTION TWO

You may fax the form and receipts to our dedicated fax line 817-735-8301

OPTION THREE

You may scan the form and receipts and email these to our email address:
criderins@aol.com

Processing your Claim

We process claims daily. Our goal is to pay the claim the same day it is received. However, there may times due to holidays, time of day we receive your claim, or your employer has not remitted payments, that it may take up to 3 business days + mail days to complete processing your claim.

DIRECT DEPOSIT

If you want us to direct deposit (ACH) your claim payment to your bank account, please call us and we will tell provide you with instructions to set up this process.

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DEPENDENT CARE CLAIM FORM

Social Security No: _____

Participant's Name: _____

To: Crider Insurance Services – Plan Administrator

The undersigned participant in the plan requests reimbursement (attach itemized bills, receipts, and invoices for all expenses claimed) in the amounts below: (If additional space is needed, please use the back of this form.)

1. NAME OF DEPENDENT(S):

2. PERIOD COVERED FROM _____ TO _____
MONTH/DAY/YEAR MONTH/DAY/YEAR

3. Name, Address and Taxpayer Identification number of person providing service and description of service:

Amount \$ _____*

* Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

PLEASE READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the employer's Cafeteria Plan with respect to such expenses and the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a prior expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature

Date

For Plan Administrator Use:

Payment Authorized: _____

Amount \$ _____

Check No. _____

Date: _____

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**DIRECT DEPOSIT INSTRUCTIONS
FLEXIBLE SPENDING ACCOUNTS**

Want a way to get your money faster and with less hassle? Then sign up for direct deposit.
IT'S SIMPLE TO DO!!!!

Procedure to start direct deposit program (you may fax your information):

1. Regular checking account

a) Send us your **VOIDED CHECK** with social security number, address, telephone number and email address.

2. Savings account

a) Bank will have a form they will complete for you to send us (include your social security number and telephone number).

3. Federal Credit Union

a) Credit union will have a form they will complete. You **MUST** note whether account is checking or savings (include your social security number and your agent number).

THAT'S IT!! THIS IS ALL WE NEED IN ORDER TO SET YOU UP ON DIRECT DEPOSIT. NO MORE WAITING FOR THE CHECK IN THE MAIL!

If you have any questions, please call Andy Crider at 800-466-2324.

Signature

Address

City, State, Zip

Social Security Number

Enclosed
Voided check _____

Phone number

Email address