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.

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Flexible Spending Account
REIMBURSEMENT REQUEST

5163106

Remember - You can submit paperless claims on-line!
File FSA claims on-line via the Participant Portal at www.gdynamic.com.

This form should not be used for debit card substantiation or HRA claims.

EMPLOYEE INFORMATION

Employee Name	Last 4 digits of Social Security #
Employer	Plan Year

DEPENDENT CARE

Enclose a copy of an itemized receipt or statement for each entry. Retain your original documentation, any documents you submit will not be returned to you.

	Provider Name	Provider SS # or Tax ID #	Services for (Name)	Relationship/Age	Dates of Service	Amount
1						
2						
					TOTAL ▸	

DEPENDENT CARE PROVIDER *If you do not have a receipt, this section must be completed.*

Provider's Name	Provider's SS # or Tax ID #		
Provider's Address Street	City	State	Zip
I certify that I have provided the services as listed above **Provider's Signature** ✕		Date	

MEDICAL CARE

Enclose a copy of an itemized receipt or statement for each entry. Retain your original documentation, any documents you submit will not be returned to you.

	Provider Name	Service(s)/Item(s) Purchased	Services for (Name/Relationship)	Date of Service	Amount
1					
2					
3					
4					
5					
				TOTAL ▸	

I have read and followed the **Claim Submission Requirements** on the back of this form.

My signature below acknowledges that I have read the Claim Submission Requirements on the back of this form, as well as 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 (HSA). 5) The expenses listed above were incurred by me and/or my eligible dependents as defined by the IRS.

✕ Employee Signature Required	Date

E-MAIL TO: claims@gdynamic.com *To protect your privacy, a secure e-mail program is available on www.gdynamic.com.*
FAX TO: 207-518-5200
MAIL TO: Group Dynamic, Inc. Reimbursement Benefits, 411 US Route One, Falmouth, ME 04105
PHONES: 207-781-8800 or 800-626-3539

CLAIM SUBMISSION REQUIREMENTS

1. **Be sure your form is complete, legible and signed.** Incomplete Reimbursement Request Forms or those lacking proper documentation will not be processed. You will receive a letter of explanation.

2. **Limit one receipt per line.** Do not include more than 2 receipts per Day Care or 5 receipts per Medical Care submissions. If additional space is needed, please use another Reimbursement Request Form.

3. **Include proper documentation to support your request**. Be sure to include an itemized receipt or statement which includes the provider's name, credentials, address, dates of service, description of service and the expense incurred. Canceled checks, check copies or credit card statements may not be used as documentation.

   For Dependent Care, if your daycare provider does not issue statements, you may complete the information on the front of this form. Your day care provider must sign the form on the *Provider's Signature* line as verification of the information that you provided.

4. **Do not send original documentation**. Retain originals of all documents, as well as this Request Form for your personal tax records. Documents you submit will not be returned to you.

5. **Reimbursement Turn-Around Time.** Reimbursements are processed weekly. All submissions received by noon on Tuesday (EST) are processed by Thursday of the same week.

6. **Letters of Medical Necessity.** In certain instances, a dated statement from your health care provider may be required to verify the medical necessity of a procedure.

7. **Mileage Reminder.** You are eligible for reimbursement for round-trip travel expenses to eligible medical appointments, including mileage, parking and tolls. Be sure to include an itemized receipt if requesting reimbursement for parking or tolls. The IRS determines the mileage reimbursement rates annually.

8. **On-Line Claim Submissions.** To submit claims electronically, go to www.gdynamic.com. Log in to the Participant Portal to submit your request and upload your supporting documentation.

9. **GDI Mobile App.** Reimbursement requests can be submitted via the mobile app. Download the free app from the app store. Submit your claim and use your mobile device's camera to upload images of supporting documentation.

If you have any questions or need assistance with filing this form, please call 800-626-3539 to speak with a member of our Reimbursement Services Team. We are here to assist you.

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