

DEPENDENT CARE REIMBURSEMENT CLAIM FORM FILING INSTRUCTIONS

Who Can File A Claim

- Only employees participating in the Cafeteria Plan can file a claim for reimbursement.
- Employees can file a claim during the Plan Year and for a certain period after the Plan Year, if allowed by the plan. Please see your Summary Plan Description for additional details.
- Terminated employees can file a claim form for a certain period after the date of termination if allowed by the Plan. Please see your Summary Plan Description.

What Expenses Can Be Claimed

- Only expenses for services **INCURRED** during the Plan Year and the associated Grace Period (if applicable) can be claimed for reimbursement.
- Qualifying expenses must be submitted after the service period has elapsed.

Qualifying Dependent Care expenses include:

- Expenses paid to a dependent care center or care provider
- Expenses paid for the care of a dependent under age 13.
- Expenses paid for the care of other dependents who are physically or mentally incapable of caring for themselves.

How Do I Complete The Form

- Complete the Employer Information section by listing your employer's name and the Plan Year beginning and ending dates.
- Complete the Employee Information section by listing your name, social security number, address and email address.
- Complete the Dependent Care expense section by indicating the period of service, the provider's name, the recipient of the expense, the recipient's date of birth, the expense type, the relationship of the recipient to the employee, and the amount being requested.
- Once all claims are listed, total the amounts and list the total in the Total Reimbursement Requested box.
- Read the Dependent Care Expense Certification carefully; then sign and date the form.

Substantiation

- Present this completed form to your Dependent Care provider to have them complete the Dependent Care Claim Substantiation Statement, or
- Include photocopies of your expense substantiation with this claim form. Please do not staple the substantiation to the form, and **DO NOT send original receipts.**
- All substantiation must be received in an 8 ½" x 11" format. **If substantiation is not received in this format, your claim form and documentation will be returned to you.**
- Substantiation must contain the following pieces of information:
 - Provider Name
 - Date/period the services were incurred
 - Recipient of the service
 - Description of service provided
 - Expense amount
- Cancelled checks and credit card statements/receipts are not considered valid substantiation.



DEPENDENT CARE REIMBURSEMENT ACCOUNT CLAIM FORM

Employer Information

Employer:	Plan Year:	through
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Employee Information

First Name:	Last Name:	Social Security Number:	-	-
Address:		City:		
State:	Zip Code:	Email Address:		

Dependent Care Expenses

Service Start Date:	Provider:		
Service End Date:	Expense for Name:	Dependent Date of Birth:	
1 Expense Type: <input type="checkbox"/> Day Care <input type="checkbox"/> Before/After School Program <input type="checkbox"/> Day Camp <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> Other: _____		Amount Requested: \$

Service Start Date:	Provider:		
Service End Date:	Expense for Name:	Dependent Date of Birth:	
2 Expense Type: <input type="checkbox"/> Day Care <input type="checkbox"/> Before/After School Program <input type="checkbox"/> Day Camp <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> Other: _____		Amount Requested: \$

Service Start Date:	Provider:		
Service End Date:	Expense for Name:	Dependent Date of Birth:	
3 Expense Type: <input type="checkbox"/> Day Care <input type="checkbox"/> Before/After School Program <input type="checkbox"/> Day Camp <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> Other: _____		Amount Requested: \$

Total Reimbursement Requested: \$

Dependent Care Expense Certification

I certify that all services for which reimbursement is requested under the Plan were incurred within the Plan Year of my election and that the expenses associated with these services have been paid by me. I will not use expenses reimbursed through my dependent care assistance account as deductions when filing my Federal Income Tax return.

I understand that I am fully responsible for the sufficiency and accuracy of all information relating to dependent care claims that are provided by me, and that unless an expense is a qualifying expense under the Plan, I may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan that relate to such expense.

Signature: _____ Date: _____

Dependent Care Claim Substantiation Statement

I hereby substantiate the claims mentioned above.

Provider Name:	Provider Tax I.D. Number:
Provider Address:	
Signature:	Date:

