

Dependent Care FSA Claim Form

Employer Name:

This claim form is for reimbursement from your Dependent Care Spending Account for dependent care expenses only. You should attach documentation to this form which supports your claims for benefits.

Employee Name (print) _____
Social Security Number

Check here if new address _____ Home Address (Street, City, State, and Zip Code)

Email Address

Amount Requested

Dates for Which Reimbursement Requested

Name of Provider

Provider Social Security # or Tax ID #

Providers Signature (in lieu of receipt)

Name(s) of Dependent(s)	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Read Carefully

I certify the dependent care expenses submitted for reimbursement meet the following requirements:

1. The expenses are either (a) for services (e.g., daycare, nursery school) or (b) for household services attributed to the care of a qualifying individual during the period I am a participant in the Dependent Care FSA. Educational expenses for a child in kindergarten or higher grades are not eligible.
2. The expenses are for either (a) a child under 13 claimed as exempt on my federal income tax return or (b) my spouse or other dependent who is physically or mentally unable to care for himself or herself.
3. The expenses are for the purpose of allowing me and my spouse to be gainfully employed during the period I have responsibility for a qualifying income. Payments to a child of mine under age 19 or to a person I or my spouse may claim as a dependent on my federal income tax return are not reimbursable expenses.
4. If married, the amount of reimbursable expenses will not exceed the lesser of my earnings or my spouses earnings for the year. If my spouse is a full-time student or physically or mentally unable to care for himself or herself, my spouse is deemed to have earnings of \$200 a month (\$400 if I have at least two qualifying individuals).

I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical care expenses are reimbursed under the Dependent Care FSA, I will not claim them as expenses for purpose of the tax deduction against income tax for medical care.

SIGNATURE _____ **DATE** _____

Claim Filing Instructions

- 1) You may submit a Claim Form only if you are a participant in the Dependent Care Spending Account.
- 2) You may submit a Claim Form at any time during the Plan Year and for a specified period after your employment terminates as stated in the Summary Plan Description.
- 3) Reimbursements can only be made for eligible expenses incurred during the coverage period in which your contributions are made.
- 4) All receipts and other supporting documents must be attached to this Claim Form. Submitting cancelled checks or credit card receipts will not be accepted as proof of payment.
- 5) Claims and supporting documents must be forwarded to:

Alliance Benefit Group - MidAtlantic, LLC.
Attn: FSA Department
575 South Charles Street, Suite 202
Baltimore, Maryland 21201
Fax (410) 895-0951

- 6) Claims will be processed according to your company's pre-determined schedule.
- 7) The IRS rules stipulate that any money left in your account(s) after all reimbursements for the
- 8) You cannot receive payment from any other source for expenses submitted for reimbursement, and you must certify that you are not eligible to bill any other source for the reimbursement
- 9) If you receive reimbursement for expenses, you cannot claim these expenses for income tax purposes.
- 10) For a service period that begins in one Plan Year and ends in the next Plan Year, you will need to submit two Claim Forms, one for each portion of the period of service that falls in each such plan
- 11) You can use a Dependent Care Spending Account only if you pay dependent care expenses to be able to work. If you are married, your spouse must also work, go to school full-time, or be incapable of self-care for your to be eligible.
- 12) Eligible expenses include those for (a) dependent care centers which comply with all applicable state and local regulations, or (b) services provided inside or outside you home by anyone other than your spouse, one of your children under age 19 or someone who is your dependent for income tax purposes.
- 13) To be reimbursed, you must include the facility's name and tax identification number or the Social Security number of the individual providing the dependent day care service.
- 14) The maximum amount you can be reimbursed during the time you are covered in the Plan Year cannot exceed the salary reduction amount you have elected for that Plan Year.

Please make a photocopy of the Claim Form and all receipts for your records.