FSA DEPENDENT CARE REIMBURSEMENT CLAIM FORM

Return completed form and receipts to:
PO Box 1587 • Pekin IL 61555-1587
www.groupplansolutions.com
Phone: 888-301-0747 • Fax: 855-545-7165
Email: flexspendhelp@groupplansolutions.com

EMPLOYEE INFORMATION

Employer Name: ____________________

Employee Name: ____________________ Employee SSN: ____________

Phone: ____________ Email: ____________________

Employee Address: ____________________ City: ____________ State: _____ Zip: ________

DEPENDENT CARE EXPENSES – All children must qualify as IRS dependents under IRS Code 152.

Name of Child/Dependent	Child/Dependent Date of Birth	Name of Child/Dependent Care Provider	Dates of Service		Amount Requested
			Beginning Date	Ending Date	
					$
					$
					$
					$
					$

DEPENDENT CARE PROVIDER CERTIFICATION – This section must only be completed if you are unable to submit copies of your paid receipts with the claim.

I provided childcare services to the above individual(s) for the amounts and dates that are listed above.

Provider Signature: X ____________________ Date: ____________

Provider Name: ____________________ Provider Phone: ____________

Address: ____________________ City: ____________ State: _____ Zip: ________

Federal Tax I.D. Number or Social Security Number of Provider: ____________________

<u>Claims cannot be processed until services have been incurred</u> according to the Internal Revenue Service regulations that govern the Section 125 plans. Claims sent in prior to the dates of service will be held until charges have been incurred. It is up to the participant to notify the plan administrator in writing of any changes.

EMPLOYEE STATEMENT

I hereby certify that the information contained on this Dependent Care Reimbursement receipt is true and correct. I understand that unless the dependent care provider provides their signature or a receipt for services along with this form this claim will not be processed. I understand and agree that only expenses that have been incurred will be processed in accordance with the IRS regulations and this Section 125 plan. I understand that if I am reimbursed for an expense that is later determined to be ineligible, the amount of the expenses will be considered taxable income to me, and I may be subject to interest & penalties by the IRS. I understand that the claims administrator is relying on my representation as to the eligibility of the expenses for reimbursement, and I acknowledge that neither my employer or Group Plan Solutions is responsible for verifying that my representations are correct. I further understand that no tax deductions or credits are permitted for which reimbursement is made under this plan.
I have read, understand, and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Form.

Signature of Employee ____________________ Date ____________

PLEASE KEEP A COPY FOR YOUR RECORDS AS RECEIPTS CANNOT BE RETURNED

Certificate of Qualifying Dependent Care Expenses

By signing and submitting this DCAP Reimbursement Request Form, you are certifying that expenses for which you request reimbursement satisfy all of the following conditions. Capitalized terms used in this Form have the meanings defined by the applicable Internal Revenue Code, Regulations, and Employer Plan Document. All distributions subject to the terms of the applicable Employer Plan.

- Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
  - a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
  - your Spouse who is physically or mentally incapable of self-care and has the same principal abode as you for more than half the year; or
  - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

  Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.
- The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, as described further in the Salary Reduction Plan Summary Description.
- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center—that is, a facility (including a day camp) that receives payment for providing care for more than six nonresident individuals on a regular basis—then the center complies with all appliable state and local laws and regulations.
- The person who provided care was not your Spouse, a parent of your under age 13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.
- You have no reason to believe that the requested reimbursement, added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed your applicable statutory limit. Your statutory limit is the smallest of the following amounts:
  - your earned income for the calendar year (after your salary reductions under the Salary Reduction Plan);
  - the earned income of your Spouse for the calendar year (your Spouse is deemed to have earned income of at least $250 ($500 is you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care (provided that you and your Spouse have the same principal place of abode for more than one-half of such year), or (b) a full-time student); or
  - either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described further in the Salary Reduction Plan Summary Description.