Dependent Care Reimbursement Account

Employee Name	Unique ID Number	Employer

Please print or type. Completed form must be sent in with attached appropriate documentation.

Expenses Incurred For:		DOB:	Relationship To Employee:	
Date Incurred	**Name and Address of Provider**	**Provider's Taxpayer ID Number (See #1 Below)**	**Location Where Services Were Provided**	**Amount of Charges**
From: To:				$
From: To:				$
From: To:				S

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From: To:				$
From: To:				$
From: To:				$

As proof of expense, please attach provider statements	**TOTAL EXPENSE ON THIS REQUEST**	$

The following conditions must be met for requested expenses to be qualified for reimbursement from your Dependent Care Expense Reimbursement Account:

1. The Provider's Name and Taxpayer Identification (TIN) or Provider (SSN) Number, if available, must be provided on this form in the column indicated.
2. If married, the total payments made under this and any other Dependent Care Plan in this taxable year will not exceed the lessor of your earned income during this taxable year, or your spouse's earned income during this taxable year.
3. The expenses are necessary to enable you and your spouse, if married, to work or actively search for employment. Your spouse must work outside the home, be a full-time student or be incapacitated.
4. Your dependent must be under age 13 and eligible to be claimed as a dependent on your Federal income tax return, or your dependent is physically or mentally incapable of caring for himself or herself (a disabled spouse or elderly parent, for example).
5. If services were provided outside the home, the dependent for whom services were incurred spends at least eight hours a day in your household.
6. If services were performed in a daycare center with six or more children who do not reside at the center, the center must comply with all applicable laws and regulations in your state.
7. The person providing the service will not be claimed as a dependent on your income tax return for the plan year in which the service was provided.

If your spouse is a full-time student, please indicate the educational institution attended and the months of attendance:_____

Is your spouse incapacitated? ☐ Yes ☐ No

I certify that the amounts herein requested for reimbursement have been actually incurred as qualified expenses during a period while the undersigned was covered under the plan, and have not, cannot and will not be reimbursed from any other benefit plan deducted on my income tax return, nor were they previously submitted for reimbursement under this Plan. I agree to provide supplemental information to process this claim as requested by the Plan Administrator. 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.

Employee Phone Number_____

Employee Signature _____ **Date** _____

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ABS Automated Benefit Services