

1. Complete a claim form for each provider.
2. Complete Section I, II, and III.
3. Submit completed original claim form or original claim form and original statements/receipt to the address shown at right.

Mail to: Dependent Care FSA Claims  
307 International Circle  
Suite 200  
Hunt Valley, MD 21030  
Fax: 1-866-879-0812

### SECTION I

Last Name (Account Holder)		First Name	Middle Initial	Employer Name
Street Address			Last 4 Digits SSN	Date of Birth
City	State	ZIP		Home Phone #/Work Phone #
Provider Name			Provider SSN or Tax ID #	

Type of Provider	Name(s) of Dependent(s)	Age(s) of Dependent(s)	Date(s) of Service	Total Work-Related Dependent Care Charges
<b>Example:</b> Daycare center	<b>Example:</b> Jonnie	4 yrs	01/02/06 to 02/01/06	\$240.00
<b>Total</b>				

### SECTION II – Provider Verification

If provider is unable to sign form, attach either an original itemized receipt or statement from the provider to this claim form as documentation.

I verify that dependent care services were performed by me or by the center I represent for the above individuals on the dates indicated above and the amount incurred for these services agrees with the amount shown above.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

### SECTION III – Account Holder Certification

I authorize the above-listed expenses to be reimbursed through my Dependent Care Flexible Spending Account. I certify that my statements in this form are true and complete to the best of my knowledge. I further certify that the above-listed expenses have not been reimbursed or paid by any other source, and that I will not seek reimbursement for them from any other source. I further certify that the above-listed expenses will not be claimed as a deduction or credit for federal or state income tax purposes. I further certify, to the best of my knowledge, that the above-listed expenses qualify as eligible expenses under my Dependent Care Flexible Spending Account and that the person receiving the care identified above is my Spouse or Dependent (as that term is defined in my plan documents and described on the back of this form).

Signature of Account Holder \_\_\_\_\_ Date \_\_\_\_\_

## GENERAL INFORMATION

Eligible dependent care expenses for which you submit a claim must be incurred during the coverage period. Eligible dependent care expenses can be submitted after the service is provided, not when services are paid for or when a service is billed. **Claims for future services will not be accepted.**

You may be reimbursed for eligible expenses incurred on behalf of any individual who is either: (i) your Dependent child who is under age thirteen (13); (ii) your Dependent, if your Dependent is mentally or physically unable to care for himself or herself and has the same principal place of abode as you for at least one-half of the year; or (iii) your Spouse, if your Spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

**Dependent child** generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, or stepsister, or a descendant of any such person, who has the same principal place of abode as you for at least one-half of the year, and does not provide over half of his/her own support during the year.

**Dependent** generally includes (i) your Dependent child who has not attained the limiting age as defined in the Dependent Care Flexible Spending Account plan and who did not provide more than half of his/her support during the relevant year, and (ii) an individual who is your son, daughter, stepson, stepdaughter, eligible foster child, descendant of a child, brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law (or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household), who generally has received more than one-half of his/her support from you during the relevant year, and who is not a "qualifying child" (as that term is defined under Section 152 of the Code) of you or someone else.

You may not claim dependent care expense deduction on your income tax return for expenses for which you were reimbursed from your Dependent Care Flexible Spending Account.

If you are married, the IRS requires that both you and your spouse earn income in order to be eligible for reimbursement of dependent care expenses—unless your spouse is disabled or a full-time student. Expenses reimbursed from the Dependent Care Flexible Spending Account cannot exceed the lesser of your earned income or the income of your spouse. If your spouse is disabled or a student, the law assumes that your spouse has a monthly income of \$250 (if you have one dependent), or \$500 (if you have two or more dependents). If your spouse is not disabled, not a full-time student, or is not earning income, the Plan cannot pay for any dependent care. Dependent

care expenses for which you submit a claim must be "employment related." This means the expenses must be necessary to allow you (and your spouse, if married) to work.

If you are divorced or legally separated from your spouse during the plan year, the parent with whom the child(ren) resides with for the greatest part of the calendar year may establish a dependent care flexible spending account (if not done so already) and seek reimbursement from such account if the child (i) is under age thirteen (13) or is physically or mentally incapable of self-care; (ii) receives over half of his or her support during the calendar year from his or her parents; and (iii) is in the custody of one or both of his or her parents for more than one-half of the calendar year.

For more information about your Dependent Care Flexible Spending Account benefits, refer to your plan documents.