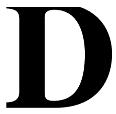

Flexible Benefits Plan
DEPENDENT CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS**

Employee Information

To update your address or email, please login to MyCrosbyBenefits.com

Please also notify employer of any address changes.

Employee Name ____
Last First MI

Employer ____

SSN / Employee ID ______________________________

Please enter your SSN or Employee ID. Many employers use an ID other than SSN with Crosby Benefit Systems. If you are unsure which number to use, please contact us or your HR/Benefits department. If you do not enter an SSN/Employee ID, Crosby will attempt to identify you based on other information but this could delay or prevent processing of your request.

Home Address ____
Street City State Zip

Email Address ______________________________

Home Phone (______)____________________ Work Phone (______)______________________
area code area code ext.

Expenses

Supporting documentation should include:
1. Name of person receiving service
2. Name of service provider
3. Nature of service
4. Amount of expense
5. Date(s) of service (not paid date)

Please list all out-of-pocket dependent care expenses for which you are requesting reimbursement.

Dependent Name & Description of Expense	Dates of Service (not paid date) Start Date	End Date	Amount
______________________________	____/____/____	____/____/____	____________
______________________________	____/____/____	____/____/____	____________
______________________________	____/____/____	____/____/____	____________
______________________________	____/____/____	____/____/____	____________

TOTAL EXPENSES $____________

Provider Signature

Provider may complete and sign here instead of providing bill or receipt.

To be completed by Provider unless third party bill or other evidence is attached.
I certify that the services listed above have been provided.

Provider Name & Address: ____

Provider Signature: ______________________________ Date: ____________________

Be sure all Supporting Documentation, as defined in Important Information section on reverse side of form, is included in the section above or is otherwise attached. Retain a copy for your records. Canceled checks are not acceptable. Failure to submit required information will delay (or prevent) claims processing.

Employee Certification

By submitting this form, I hereby certify the following:

- The expenses listed above are "Eligible Employment Related Expenses" as defined in the Summary Plan Description ("SPD"). See reverse side for general information regarding Eligible Employment Related expenses.
- The expenses are for the custodial care of one or more "Qualifying Individuals" as defined in your SPD. (Note: See reverse side for general information regarding "Qualifying Individuals".)
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I have obtained or made reasonable efforts to obtain the provider's taxpayer identification number ("TIN") and I will include that TIN on the Form 2441 that I attach to my federal income tax return.
- If the provider is a dependent care center which provides care for six (6) or more individuals, the center complies with all applicable state laws.

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Please **SIGN**

Employee Signature ____ **Date** ____________________

IMPORTANT INFORMATION

Please note: Nothing in this section is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between this section of the Form and the SPD, the SPD controls.

Dependent Care Eligible Expenses - The annual amount reimbursed cannot exceed the amount set forth in the SPD. The expenses must be "Eligible Employment Related Expenses" as defined in your SPD. Generally, Eligible Employment Related Expenses are expenses for the custodial care of one or more Qualifying Individuals that enable you (and your spouse, if applicable) to work or to look for work.

A "Qualifying Individual" is defined in more detail in your SPD. Generally, a Qualifying Individual is any one of the following:

- A "qualifying child" (as defined in Code Section 152(c)) for whom you are entitled to an exemption under 151 who is under the age of 13 and who resides with you for more than half of the year;
- A dependent (as defined below) that is incapacitated and resides with you for more than half of the year; or
- A legal spouse who is incapacitated and resides with you for more than half of the year.

A "dependent" for purposes of identifying certain Qualifying Individuals is any individual who meets the requirements described in Code Section 152 without regard to subsections (b)(1), (b)(2) and (d)(1)(B). Generally, this will be anyone whom you could claim as a dependent on your tax return (as defined by Section 152) and anyone that you could otherwise claim as a dependent on your federal tax return but for the fact that:

- The individual has income in excess of the income threshold established for "qualifying relatives" defined under Code Section 152(d)
- You are a dependent of another person, or
- The individual is a child of yours who is married and files a joint tax return with his/her spouse.

Dependent Care expenses are not eligible if paid to a person who is claimed as a dependent by the employee. Every dollar that you are reimbursed tax free under this plan for Eligible Employment Related Expenses reduces the base amount for which you may be eligible for the Dependent Care Credit under Code Section 21. If you plan to also take a credit for Eligible Employment Related Expenses, you should consult with a qualified tax or legal advisor.

You are required to include the name, address, and TIN of the service provider on the Form 2441 that you must attach to your federal income tax return. Overnight camp is not an allowable expense**,** even on a prorated basis. Kindergarten is not an allowable expense.

Dependent care expenses submitted <u>before</u> the service is provided are not reimbursable. If a claim is submitted in advance of the actual service date, it may be denied. For example, expenses for a particular month should not be submitted until the last day of that month. If services are provided by a dependent care center, which provides care for more than six individuals (other than a resident of the facility), the center must comply with all state and local laws.

Supporting Documentation - All expenses require the information noted below for approval. These may be provided by completing the Provider Signature section on the reverse of this form, or by attaching third party bills or other evidence that includes:

1. Name of person receiving the service
2. Name and address of service provider
3. Nature of service
4. Amount of expense
5. Date(s) of service (not paid date)

Submission of Reimbursement Requests - Fax (preferred), email or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable.

Please Note - Service dates for reimbursable expenses must fall within the plan year (or grace period, if adopted by the employer). Expenses must be incurred on or after the participant's effective date and before the end of the plan year (or grace period, if adopted by the employer). After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status or cost or coverage change.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.