Dependent Care Claim Form Instructions

(Do not fax or mail this instruction page)

Options: ***Please use option 1 for faster reimbursement***

1. Online: Log in to your account. Submit your claim online and attach the image or scanned copy of your receipt.

2. Fax or Mail: Enter the claim online, then print the online fax cover sheet and submit the cover sheet and receipt through Fax or Mail. Otherwise complete and sign this claim form attaching the copy of your receipt and submit through Fax or Mail.

Fax: **1.866.228.9417**

Mail: **Spending Account Processing**

PO Box 25173, Lehigh Valley, PA 18002-5173

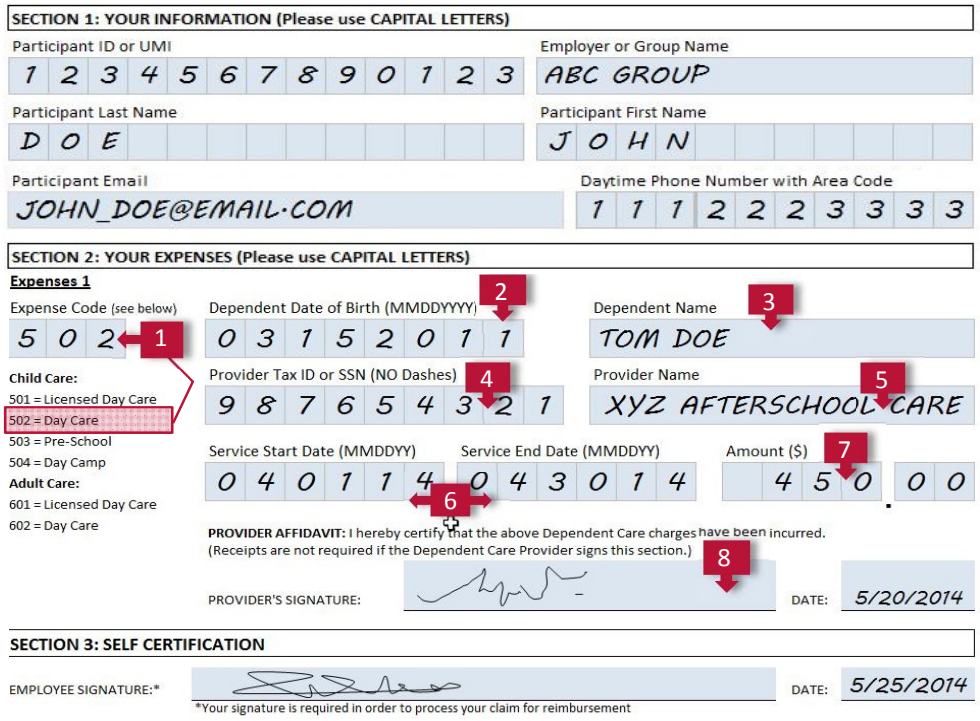
-- Please make sure that you fax or mail the claim form and the related supporting documentation together. The claim form should be the first page in the stack of pages that you fax.

Instructions:

• Please print or write in capital letters, with the letters centered in the boxes
• Complete all information of " Your Information"- Section 1
• Use your documentation to complete "Your Expenses"- Section 2 of the form, including the following:

1. Choose your expense type from the list
2. Enter date of birth of the dependent
3. Write dependent name
4. Enter Tax ID or SSN of your service provider
5. Write the care provider name
6. Enter service start & end date
7. Enter the requested amount
8. You don't need to send documentation if your service provider signs here.

• Read the certification of Section 3 and then Sign and date the form



Acceptable Supporting Documentation:

• Provider signature in the provider affidavit section of this claim form OR
• Copy of itemized receipts of your dependent care expenses. Receipt must show:
- Name of the care provider
- Tax ID number or Social Security Number of the care provider
- Date of services for which you are being charged
- Amount you are being charged
- Include your dependent's name

Unacceptable Supporting Documentation:

• Credit or debit card receipt, canceled checks or other payment statements are not considered acceptable evidence
• Original receipts or supporting documentations. Keep originals for yourself and send copies.

Notes:

In general, and subject to the rules of your employer's plan, the following rules apply to dependent care expenses:
• The individual receiving the care must be a child under the age of 13 or other dependents who are physically or mentally incapable of caring for themselves
• The expenses must be incurred so that you and your spouse, if married, can work or your spouse can attend school on a full-time basis
• Services provided by a child care or elder care center must comply with all state and local laws to be eligible for payment
• You can be reimbursed only for services that have been received

Dependent Care Claim Form

Fax to: 1.866.228.9417

or Mail to: Spending Account Processing, PO Box 25173, Lehigh Valley, PA 18002-5173

Go Paperless! You won't need to complete paper forms anymore. Submit online and expedite reimbursement.

SECTION 1: YOUR INFORMATION (Please use CAPITAL LETTERS)

Participant ID or UMI

Employer or Group Name

Participant Last Name

Participant First Name

Participant Email

Daytime Phone Number with Area Code

SECTION 2: YOUR EXPENSES (Please use CAPITAL LETTERS)

Expenses 1

Expense Code (see below)

Child Care:
501 = Licensed Day Care
502 = Day Care
503 = Pre-School
504 = Day Camp
Adult Care:
601 = Licensed Day Care
602 = Day Care

Dependent Date of Birth (MMDDYYYY)

Dependent Name

Provider Tax ID or SSN (NO Dashes)

Provider Name

Service Start Date (MMDDYY)

Service End Date (MMDDYY)

Amount ($)

PROVIDER AFFIDAVIT: I hereby certify that the above Dependent Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE:

DATE:

Expenses 2

Expense Code (see below)

Child Care:
501 = Licensed Day Care
502 = Day Care
503 = Pre-School
504 = Day Camp
Adult Care:
601 = Licensed Day Care
602 = Day Care

Dependent Date of Birth (MMDDYYYY)

Dependent Name

Provider Tax ID or SSN (NO Dashes)

Provider Name

Service Start Date (MMDDYY)

Service End Date (MMDDYY)

Amount ($)

PROVIDER AFFIDAVIT: I hereby certify that the above Dependent Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE:

DATE:

More expenses? Please complete another claim form.

SECTION 3: SELF CERTIFICATION

I certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the program, and that these expenses have not been reimbursed or are not reimbursable under any other plan/program. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms of the program and have read the information on this form. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

EMPLOYEE SIGNATURE:*

DATE:

*Your signature is required in order to process your claim for reimbursement