Print Form

# DEPENDENT CARE REIMBURSEMENT REQUEST FORM

**Employee**
**Name:** _____ **SS#:** _____ **Employer Name:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home Phone #:** _____ **Work Phone #:** _____

**INSTRUCTIONS:** Use this form and fill in all the information requested below to request reimbursement for eligible dependent care expenses. See the following page for complete instructions.

| | **EXAMPLE** | EXPENSE #1 | EXPENSE #2 | EXPENSE#3 | EXPENSE #4 |
|---|---|---|---|---|---|
| Date(s) Dependent Care Service Provided | **10/7/10/ to 10/14/10** | _____ to _____ | _____ to _____ | _____ to _____ | _____ to _____ |
| Name and Age of Dependent | **Fred Jones Age 4** | | | | |
| Name and Address of Provider & TIN# or SS# | **Day Care Inc. 123 Main St. Anytown, TX TIN# 74-12345** | | | | |
| Total Expense | **$250.00** | $ | $ | $ | $ |
| Reimbursement Requested | **$250.00** | $ | $ | $ | $ |

***Dependent Care***
**Total Amount Claimed: $**

To the best of my knowledge and belief, my statements in this Dependent Care Reimbursement Request Form are complete and true. I understand that these dependent care expenses may not be used to claim any Federal Income Tax deductions or credit (including the Dependent Care Tax Credit). I agree to file IRS form 2441 with my tax return and provide any taxpayer identification number required thereon. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance will be forfeited and will remain with the employer at the end of the Plan Year.

_____ Employee Signature

_____ Date

_____ Email Address

**NATIONAL PLAN ADMINISTRATORS, INC.**
**P.O. BOX 161630**
**AUSTIN, TX 78716**
**PHONE: (512) 327-6481 or (800) 880-2776**
**FAX: (512) 275-9396 or (800) 982-8140**
**EMAIL: 125@natlplan.com**
**WEBSITE: www.natlplan.com**

# QUALIFYING DEPENDENT CARE EXPENSES

The Cafeteria Plan Document contains the rules governing what expenses are covered. By signing and submitting this Dependent Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet all the following conditions:

1. The expenses are incurred so you (and your spouse, if you are married) can work or look for work.
2. The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of:
   (A) your earned income; or
   (B) if you are married, your spouse's actual or deemed earned income.
3. Each dependent for whom you incur the expenses is:
   (A) a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return, or
   (B) your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of caring for him or herself.
4. The expenses are incurred for the care of a dependent, or for related incidental household services.
5. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 3(A) above (or who is described in 3(B) above and regularly spends at least 8 hours per day in your household).
6. If the expenses are incurred for services provided by a dependent care center (i.e. a facility that provides care for more than 6 individual not residing at the facility), the center complies with all applicable state and local laws and regulations. Expenses are not paid for services at a camp where the dependent stays overnight.
7. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.

# PROCEDURE FOR SUBMITTING A CLAIM

Section 125 of the Internal Revenue Code stipulates the requirements for an expense to be reimbursed under a Dependent Care Reimbursement Account (DCA):

1) The expense must be an eligible expense.

2) There must be documentation from an independent provider that the expense was incurred. Itemized statements, receipts and bills are acceptable documentation. Canceled checks, adding machine tapes, and credit card statements are not acceptable. The documentation must include:

   - Date(s) of service,
   - Name(s) of the person(s) for whom the service was provided,
   - A breakdown of all charges or services,
   - Provider's name, address and signature,
   - Provider's tax identification number or social security number,
   - Total amount of payment for which you are seeking reimbursement.

3) There must be a signed statement that the expense has not been previously reimbursed and is not reimbursable under any health plan.

4) Dependent care claims will be reimbursed up to the balance available in the claimant's Dependent Care Account at the time a claim is processed.

5) There will be no reimbursement of dependent care before the care has been incurred even if payment has been made in advance. Dependent care claims will only be reimbursed **after** the care has been incurred.

**NOTES:** Dependent Care Reimbursement Request Forms are available on line at www.natlplan.com/employees.html.

Please keep a copy of all records submitted to NPA.