



Request for Reimbursement Dependent Care Spending Account

Instructions

1. Employee must complete **Employee Information** – Be sure to indicate if this is a new address.
2. Complete **Claim Information** in its entirety. Please ensure that your supporting documentation clearly indicates the requested amount.

Eligible expenses include but are not limited to: After-school care of Extended Day Program for a child <13. Au Pair for a child <13, babysitter in or out of the home for a child <13, custodial or elder day care expenses of a qualified dependent, disables spouse or tax dependent day care of a qualified dependent, educational expenses for pre-school/nursery school, FICA/FUTA taxes of the day care provider, nanny day care expenses for a child <13, sick child facility for a child <13, summer day camp for a child <13.

Ineligible Expenses include but are not limited to: Assisted living expenses, airfare, living expenses or other fixed costs for a nanny or au pair, gardening services, housekeeping services, kindergarten expenses, nursing home expenses, overnight camp expenses, transportation expenses, meals, registration fees and educational expenses (tuition).

3. Check the appropriate box in **Provider Certification**. If the provider signs the claim form, additional documentation is not required. If not signed, attach an itemized statement, receipt or bill from your day care provider including: Provider Information, Dependent name, Date(s) of service, and Itemization of charges. When attaching small receipts, we suggest you tape them to a standard size sheet of paper,
 4. Sign and date **Employee Certification**
 5. **Submit Claims To:**
CONEXIS Cafeteria Plan Services
P.O. Box 227197
Dallas, Texas 75222
Fax: (888) 866-3312 Phone: (866) 279-8385
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Employee Information

Employer Name _____ Check here if this is a new address

Employee Name _____ Social Security Number _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ Zip Code _____

Claim Information

Name of Day Care Provider _____ Tax ID Number/SSN _____

Street Address _____ City _____ State _____ Zip Code _____

Dates of Service _____ Through _____ Total Charges \$ _____

Dependent Name	Date of Birth	Date(s) of Service(MM/DD/YYYY)	Requested Amount
_____	_____	From: _____ To: _____	\$ _____
_____	_____	From: _____ To: _____	\$ _____
_____	_____	From: _____ To: _____	\$ _____
_____	_____	From: _____ To: _____	\$ _____

Total Amount Requested (continue on additional page if necessary) \$ _____

Provider Certification

I certify that the above services have been provided.

Provider Signature Date

If the provider signs the claim form, additional documentation is not required

- My provider has signed the claim form..
- I have attached itemized receipt(s) or statement(s) from my day care provider.

I certify the expenses listed for reimbursement are eligible dependent care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan. I also certify the services listed above have been received by my dependent. These expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person. My employer does not accept responsibility for direct payment to any individuals other than the employee. I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that any unused contributions will be forfeited to my employer at the end of the plan year. I agree to file IRS Form 2441 with my tax return.

Employee Signature Date