DEPENDENT CARE REIMBURSEMENT REQUEST FORM

Employee			Employer			
Name:		SS#: _		_ Name:		
Address:		City: _		State:	Zip:	
Home Phone #:		Work Phone	e #:			
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: \$			
and true. I understan credit (including the identification number	d that these depend Dependent Care Tax required thereon. I	my statements in this ent care expenses ma c Credit). I agree to f also acknowledge tha feited and will remain	ay not be used to clai ile IRS form 2441 wit at should the actual a	m any Federal Incom h my tax return and p nnual expenses clain	ne Tax deductions or provide any taxpayer ned be less than the	
Employee Signature		Date	Ema	ail Address		



NATIONAL PLAN ADMINISTRATORS, INC.

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EMAIL: <u>125@natlplan.com</u>
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.