FLEX BENEFIT SYSTEMS
23882 Hall Road
Cheshire, OR 97419
541-998-8705

Plan Year: ___________

DEPENDENT CARE RECEIPT/CLAIM FORM

Employee:____ **Company:**____

Dependent Name:___________________________________ **Dependent Year of Birth:** ____________________________

Period of Time: ___________________________________ **Total Cost:** $_____________________________________

Description of Service Provided:____

PROVIDER: ____

ADDRESS: ____

____

TIN # OF PROVIDER: ____
(SOCIAL SECURITY NUMBER or FEDERAL ID NUMBER)

SIGNATURE OF PROVIDER: _____________________________________
(If no bill or receipt is attached)

To the best of my knowledge and belief my statements in this Form are complete and true. I certify all of the following: My family member has received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Dependent Care Expenses under the Plan. The expenses listed are for my Dependent as defined in the Plan. I have not been reimbursed previously for these expenses under the DCAP. These expenses have not been reimbursed and I will not seek reimbursement for them under insurance or any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. The amount of reimbursement requested in this Form, added to the reimbursements to date (from any plan) does not exceed the statutory limits described in the Summary Plan Description. I have read, understand and make the certifications contained in the instructions at the bottom of this Form. I authorize a deduction to my DCAP Account in the amount of the reimbursement.

Employee's Signature:____ **Date:**___________________________

INSTRUCTIONS

1. DEPENDENT CARE EXPENSES MUST BE DOCUMENTED! Attach a copy of your receipt, bill or contract or have your dependent care provider sign this claim form.
2. Claims for dependent care expenses are legal only if you must pay these expenses to be able to work, look for work or attend school. If you are married, your spouse must be employed, a full-time student or incapable of self-care and regularly spends 8 hrs./day in your household.
3. Coverage includes only dependents under the age of 13 or dependent adult/child who is not capable of self-care. The dependent must qualify under the federal tax code as a dependent, but it is not necessry to actually able to claim the dependent as a tax exemption.
4. You may claim reimbursement for payments to childcare centers, nursery schools and schools for children up to but not including kindergarten. Eligible expenses also include payment for summer day camps, after-school care and elderly care. Care within your home by a non-relative or a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), as long as such a person is reporting payments as income, is also eligible.
5. The expenses were incurred for services rendered after the date of your election to receive DCAP benefits and during the Plan Year to which this reimbursement applies.
6. Maximum contributions can equal the SMALLER of:
   (a) your income or your spouse's income, whichever is smaller. If your spouse is a full-time student or incapable of self-care, your spouse is considered to earn $2400 per year with one dependent or $4800 per year with two or more dependents, OR
   (b) $5000 if you file "married filing jointly" or "single head of household"; or $2500 if you file "married filing separately"
7. You cannot claim any expenses reimbursed through this or any other Flexible Benefits Plan on your income tax return. Do not take the child care tax credit on your return except for amounts which were NOT reimbursed through the Plan.

Claims are due the 18th of each month