MedBen Group # 70002

DEPENDENT CARE SPENDING REIMBURSEMENT REQUEST FORM

Employee Name: ______________________________ SS#: ______________________

Address: ____

Instructions: Complete the information below for dependent care expenses incurred by you or your spouse for which you request reimbursement. You must provide a bill or receipt from your dependent care provider or other evidence that the expenses were incurred (canceled checks will not be accepted). Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form. **Send this form along with your supporting documentation to: MedBen, Specialty Services Unit, 1975 Tamarack Rd., P. O. Box 1096, Newark, OH 43058-1096.**

	Expense # 1	**Expense # 2**	**Expense # 3**	***EXAMPLE***
Date Dependent Care Service Was Actually Provided				*10-1-99 to 10-31-99*
Name and Age of Dependent	________ Age	________ Age	________ Age	*Jane Doe* *5 Age*
Name and Address of Dependent Care Provider Tax ID # or Social Security #				*Happy House* *111 Street* *Anytown, US 11111* *00-0000000 or* *111-11-1111*
Reimbursement Requested	$	$	$	*$ 100.00*

To the best of my knowledge and belief, my statements on this Reimbursement Request Form are complete and true. I have read, understand and made the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Request form. I understand that these dependent care expenses may not be used to claim any Federal income tax deduction 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 authorize a reduction in my Dependent Care Assistance Account in the amount of the reimbursement.

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

______________________________ Employee Signature

______________________________ Date

Specialty Services Unit •1975 Tamarack Road • P.O. Box 1096 • Newark, OH 43056-1096
COBRA Phone (800) 297-1849 • FSA/HRA Phone (800) 297-1829 • fax (740) 522-7483
www.medben.com • admin@medben.com

CERTIFICATE OF QUALIFYING DEPENDENT CARE EXPENSES

By signing and submitting this Dependent Care Reimbursement Request Form, you certify that expenses for which you request reimbursement meet ***all*** of the following conditions:

1. The expenses are incurred for services rendered after the date of your election to receive dependent care assistance benefits and during the plan year to which the election applies.

2. The expenses are incurred so you (and your spouse, if you are married) can work or look for work. Exception: If your spouse is not working or looking for work when the expenses are incurred, you certify that he or she is a full-time student or is physically or mentally incapable of caring for him or herself.

3. 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.

4. 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 himself or herself.

5. You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a person described in 4(a) or 4(b) above.

6. The expenses are incurred for the care of a dependent, or for related incidental household services.

7. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 4(a) above or who is described in 4(b) above and regularly spends at least 8 hours per day in your household.

8. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provided care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

9. The person who provided care was not your spouse or a person whom you 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.

10. The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

11. The expenses were not paid for educational purposes (i.e., for a facility that provides day care and kindergarten classes, charges must be broken down between the day care and kindergarten expenses).

Required supporting documentation:

- A bill or receipt **(including date(s) services were provided, name of dependent, provider name-address-phone number, amount, Tax ID number or Social Security number)** from a childcare or adult care provider.

or

- Completed Dependent Care Receipt for Services Form from a childcare or adult care provider.

Employees may not submit proof of payment in the form of a cancelled check or credit/debit card receipt unless it is accompanied by the other required documentation.