



# Flexible Benefits Plan DEPENDENT CARE Reimbursement Request

PLEASE PRINT CLEARLY

CROSBY BENEFIT SYSTEMS, INC.

**Employee Information**

To update your address or email, please login to MyCrosbyBenefits.com  
Please also notify employer of any address changes.

Employee Name \_\_\_\_\_  
Last First MI

Employer \_\_\_\_\_

SSN / Employee ID \_\_\_\_\_  
Please enter your SSN or Employee ID. Many employers use an ID other than SSN with Crosby Benefit Systems. If you are unsure which number to use, please contact us or your HR/Benefits department. If you do not enter an SSN/Employee ID, Crosby will attempt to identify you based on other information but this could delay or prevent processing of your request.

Home Address \_\_\_\_\_  
Street City State Zip

Email Address \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_  
area code area code ext.

**Expenses**

Please ensure your supporting documentation includes:  
 1. Name of person receiving service  
 2. Name of service provider  
 3. Nature of service  
 4. Amount of expense  
 5. Date(s) of service (not paid date)

Please list all out-of-pocket dependent care expenses for which you are requesting reimbursement.

Description of Expense	Dates of Service (not paid date)		Amount
	Start Date	End Date	
_____	____/____/____	____/____/____	_____
_____	____/____/____	____/____/____	_____
_____	____/____/____	____/____/____	_____
_____	____/____/____	____/____/____	_____
_____	____/____/____	____/____/____	_____
_____	____/____/____	____/____/____	_____
<b>TOTAL EXPENSES</b>			<b>\$ _____</b>

**Include with this form all "Supporting Documentation" as defined in the Important Information section on the reverse side of this form.** Retain a copy for your records. Canceled checks are not acceptable. Failing to submit Supporting Documentation will delay (or prevent) claims processing.

**Employee Certification**

By submitting this form, I hereby certify the following:

- The expenses listed above are "Eligible Employment Related Expenses" as defined in the Summary Plan Description ("SPD"). See reverse side for general information regarding Eligible Employment Related expenses.
- The expenses are for the custodial care of one or more "Qualifying Individuals" as defined in your SPD. (Note: See reverse side for general information regarding "Qualifying Individuals".)
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I have obtained or made reasonable efforts to obtain the provider's taxpayer identification number ("TIN") and I will include that TIN on the Form 2441 that I attach to my federal income tax return.
- If the provider is a dependent care center which provides care for six (6) or more individuals, the center complies with all applicable state laws.

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Please  
**SIGN**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

## IMPORTANT INFORMATION

**Please note: Nothing in this section is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between this section of the Form and the SPD, the SPD controls.**

**Dependent Care Eligible Expenses** - The annual amount reimbursed cannot exceed the amount set forth in the SPD. The expenses must be “Eligible Employment Related Expenses” as defined in your SPD. Generally, Eligible Employment Related Expenses are expenses for the custodial care of one or more Qualifying Individuals that enable you (and your spouse, if applicable) to work or to look for work.

A “Qualifying Individual” is defined in more detail in your SPD. Generally, a Qualifying Individual is any one of the following:

- A “qualifying child” (as defined in Code Section 152(c)) who is under the age of 13 and who resides with you for more than half of the year;
- A dependent (as defined generally in Code Section 152) that is incapacitated and resides with you for more than half of the year\*; or
- A legal spouse who is incapacitated and resides with you for more than half of the year.

\*Currently, an individual (other than an individual who qualifies as a “qualifying child” of the employee) cannot qualify as a dependent under Code Section 152 if he/she has income equal to or in excess of \$3,200 (adjusted for inflation). You should consult with qualified tax or legal advisor to determine if individuals for whom you are submitting reimbursement requests qualifying as Qualifying Individuals.

Dependent Care expenses are not eligible if paid to a person who is claimed as a dependent by the employee. Every dollar that you are reimbursed tax free under this plan for Eligible Employment Related Expenses reduces the base amount for which you may be eligible for the Dependent Care Credit under Code Section 21. If you plan to also take a credit for Eligible Employment Related Expenses, you should consult with a qualified tax or legal advisor.

You are required to include the name, address, and TIN of the service provider on the Form 2441 that you must attach to your federal income tax return. Overnight camp is not an allowable expense, even on a prorated basis. Kindergarten is not an allowable expense.

Dependent care expenses submitted before the service is provided are not reimbursable. If a claim is submitted in advance of the actual service date, it may be denied. For example, expenses for a particular month should not be submitted until the last day of that month. If services are provided by a dependent care center, which provides care for more than six individuals (other than a resident of the facility), the center must comply with all state and local laws.

**Supporting Documentation** - For all expenses, attach third party bills or evidence of charges that clearly state all of the following:

1. Name of person receiving the service
2. Name of service provider
3. Nature of service
4. Amount of expense
5. Date(s) of service (not paid date)

**Submission of Reimbursement Requests** - Fax (preferred), email or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you or emailed if you have selected electronic communications delivery. You may resubmit expenses with proper documentation, if applicable.

**Please Note** - Service dates for reimbursable expenses must fall within the plan year (or grace period, if adopted by the employer). Expenses must be incurred on or after the participant’s effective date and before the end of the plan year (or grace period, if adopted by the employer). After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status or cost or coverage change.

Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.

