

Dependent Care Flexible Spending Account Claim Form

Worcester County Board of Education

This claim form is for reimbursement from your Flexible Spending Account for health care expenses only. You should attach documentation to this form which supports your claims for benefits.

Employee Name (print)

Social Security Number

Check here if new address.

Home Address (Street, City, State, and Zip Code)

Email Address

Amount Requested

Date (s) of Service

Name of Provider

Providers Signature (in lieu of receipt)

Provider Social Security # or Tax ID #

Name(s) of Dependent(s)

Date of Birth

Relationship

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Read Carefully

I certify the dependent care expenses submitted for reimbursement meet the following requirements:

1. The expenses are either (a) for services (e.g., daycare, nursery school) or (b) for household services attributed to the care of a qualifying individual during the period I am a participant in the Dependent Care FSA. Educational expenses for a child in kindergarten or higher grades are not eligible.
2. The expenses are for either (a) a child under 13 claimed as exempt on my federal income tax return or (b) my spouse or other dependent who is physically or mentally unable to care for himself or herself.
3. The expenses are for the purpose of allowing me and my spouse to be gainfully employed during the period I have responsibility for a qualifying income. Payments to a child of mine under age 19 or to a person I or my spouse may claim as a dependent on my federal income tax return are not reimbursable expenses.
4. If married, the amount of reimbursable expenses will not exceed the lesser of my earnings or my spouses earnings for the year. If my spouse is a full-time student or physically or mentally unable to care for himself or herself, my spouse is deemed to have earnings of \$200 a month (\$400 if I have at least two qualifying individuals).

I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical care expenses are reimbursed under the Dependent Care FSA, I will not claim them as expenses for purpose of the tax deduction against income tax for medical care.

SIGNATURE _____

DATE _____

Claim Filing Instructions

1. You may submit a Claim Form only if you are a participant in the Health Care Spending Account.
2. You may submit a Claim Form at any time during the Plan Year and for a specified period after your employment terminates as stated in the Summary Plan Description.
3. Reimbursements can only be made for eligible expenses incurred during the coverage period in which your contributions are made.
4. All receipts and other supporting documents must be attached to this Claim Form. Submitting cancelled checks or credit care receipts will not be accepted as proof of payment.
5. Claims and supporting documents must be forwarded to:

Alliance Benefit Group -MidAtlantic, LLC
Attn: FSA Department
575 South Charles Street, Suite 202
Baltimore, Maryland 21201
Fax (410) 895-0951

6. Claims will be processed according to your company's pre-determined schedule.
7. The IRS rules stipulate that any money left in your account(s) after all reimbursements for the Plan Year have been processed cannot be carried forward or returned.
8. You cannot receive payment from any other source for expenses submitted for reimbursement, and you must certify that you are not eligible to bill any other source for the reimbursement expenses.
9. If you receive reimbursement for expenses, you cannot claim these expenses for income tax purposes.
10. For a service period that begins in one Plan Year and ends in the next Plan Year, you will need to submit two Claim Forms, one for each portion of the period of service that falls in each such plan year.

Please make a photocopy of the Claim Form and all receipts for your records.