



Flexible Spending Account Dependent Care Claim Form

IMPORTANT NOTE

Please use this form when filing a claim for reimbursement only.
Do not use this form when submitting receipts for debit card transactions.

Employer: _____

Employee Name: _____ Social Security Number: _____ - -

Phone: _____ E-mail (Optional): _____

Please complete this claim form. Incomplete forms will be returned to you. To expedite your claim, please provide all appropriate information and review the Total Dependent Care Expense amount.

Name of Qualifying Individual	Period Covered From	To	Name and Address of Service Provider	Amount Incurred
Total Dependent Care Expense Claim(s)			\$	
<p><i>Please include copies of receipts from your daycare provider or include the daycare provider's signature. Receipts must show the amount and date(s) the services were provided.</i></p>		<p>By signing below, I certify that the information above regarding the dependent care claim is accurate.</p> <p>Provider's Signature: _____</p>		

Please Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earned income of \$250 if there is one (1) qualifying individual, or \$500 if there are two (2) or more.)

Read Carefully: By signing below, I certify the following: That the expense(s) for which reimbursement is requested were provided while I was covered under the Plan; The expense(s) were necessary to enable me (and my spouse, if married) to work or look for work; The Qualifying Individual(s) identified above satisfy the requirements to be a "Qualifying Individual", as set forth in the Plan and as otherwise required by IRC Section 21; That the dependent care expenses have not been reimbursed from any other source, nor will reimbursement be sought from any other source; All information provided above is complete and accurate and that failure to provide complete and accurate information may result in adverse tax consequences.

Employee Signature _____
Date

Mail the claim form and copies of your receipts to: Altus Benefit Administrators, PO Box 1643, Providence, RI 02901-1643, or fax to: 401-457-7266.



Flexible Spending Account Dependent Care Claim Filing Instructions

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

To qualify for reimbursement from your Dependent Care Spending Account, the following is required:

1. Dependent care expenses must be incurred to enable you (and your spouse, if married) to work or look for work.
2. The person providing the dependent care service must not be a child of yours under age 19, or a dependent for whom you will be entitled to a personal exemption on your federal income tax return or a parent of the child.
3. The individual being cared for must be a "Qualifying Individual". Generally, a Qualifying Individual is any one of the following:
 - A "qualifying child" (as defined by Internal Revenue Code Section 152(a)(1)) who is under the age of 13 and who resides with you for more than half of the year; or
 - A legal spouse or tax "dependent" (as defined generally in Code Section 21) who is incapacitated and who resides with you for more than half of the year.Contact your tax or legal counsel if you have questions regarding the definition of "dependent" for purposes of Code Section 21.
4. You cannot receive more than actual salary reductions made and reported to Altus Benefit Administrators as of the date your claim is processed.
5. Expenses must be incurred on or after the participant's effective date for the plan year and before the end of the plan year (or grace period, if adopted by the employer). In accordance with IRS rules, reimbursements will not be made until the expenses have been incurred. An expense is deemed "incurred" when the services giving rise to the expenses have been provided without regard to whether you have paid for the services (i.e. advance reimbursements are prohibited).

How to file a claim

- Complete the top portion of the claim form by filling in the employee's name and Social Security number.
- In the claims section, complete all information for each amount requested for reimbursement.
- Sign and date the claim form.
- Attach a copy of a bill, invoice or other written statement from the third party daycare provider that supports each reimbursement request and shows the amount and the date the services were provided **or**, alternatively, have the daycare provider sign the claim form in the Provider's Signature box.

Cancelled checks, credit cards slips or statements showing only a balance due on your account are **not** accepted as valid receipts.

- Mail or fax the claim form and copies of your receipts to:
Altus Benefit Administrators
PO Box 1643
Providence, RI 02901-1643
Fax: (401) 457-7266

Note: You will be required to provide the name, address and taxpayer ID number (TIN) or, if no TIN, the Social Security number of the dependent care provider on your federal income tax return. The expenses you are able to consider for purposes of the federal Dependent Care Credit in IRC Section 21 is reduced by the amount of expenses reimbursed through your Dependent Care Spending Account.

Important Reminder: The Dependent Care Claim Form is used when filing a claim for reimbursement only. Please **do not** use this form when submitting receipts for debit card transactions.