

ELMS COLLEGE
Dependent Care Account Reimbursement Request Form
Plan Year: 7/1/2011 – 6/30/2012

Employee Name: _____

Address (Street, City, State, Zip): _____

Submit Claims To: BFP Associates – PO Box 478 West Springfield, MA 01090

Questions? Call us at 413.739.2352, or email: kbradway@bfpassociates.com

Instructions: All areas below must be completed by you, if the form is incomplete it will be returned to you unprocessed. *Read the reverse side of this form for further instructions and information.*

Dependent Care Expenses – for those under the age of 13 or disabled

| | | | | | |
|-----------------------------------------------------|-------------------------------|---------------|---------------|---------------|---------------|
| | <i>Example</i> | | | | |
| Date(s) Dependent Care Service Provided | 9/1/00 - 9/30/00 | | | | |
| Dependent Name -> | Sally Brown | | | | |
| Dependent Age -> | Age 5 | Age | Age | Age | Age |
| Provider Name -> | Sue Smith | | | | |
| Provider ID (or SS# for an individual) -> | 123-45-6789 | | | | |
| Provider Address -> | 123 Any Street Seattle, WA | | | | |
| Proof of Expenses Attached? | X Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| Number of Bills Attached | 2 | | | | |
| Reimbursement Requested | \$200 | \$ | \$ | \$ | \$ |
| TOTAL REIMBURSEMENT REQUESTED | | | | | \$ |

I certify that:

- To the best of my knowledge and belief, my statements in this Form are complete and true, *AND I have read the reverse side of this form.*
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 pay) for the year, if either of our income is less than \$5000.
- My eligible dependent under the age of 13 or disabled has received the services described above, and the expenses are my out-of-pocket expenses that qualify as valid Dependent Care Expenses under the Plan. These expenses were incurred so that my spouse and I, if married, can work, look for work or my spouse can attend school full-time.
- I have not been reimbursed previously for these expenses under the Plan. These expenses are not reimbursable under any other health plan, such as my Spouse's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) that I am requesting reimbursement for must be incurred during my period of coverage, and is equal to my payroll deductions.
- I will have until 9/15 of the following plan year to submit my claim for reimbursement for expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account in accordance with the IRS rules.
- The expenses that I am reimbursed may not be used to claim any federal income tax deduction or credit.

Employee Signature* _____ **Date*** _____

**Your signature and the date are required in order to process your claim for reimbursement*

| | | | | |
|----------------------------|-----------------------|---------------|----------------------|--------------------|
| For Office Use Only | Date processed | Check# | Amount Denied | Amount Paid |
| Notes: | | | \$ | \$ |

Reimbursement instructions:

1. Complete the information on the front side of this form for Dependent Care Expenses incurred by your eligible Dependent(s).
2. Services provided by a child care or elder care center must comply with all state and local laws to be an eligible reimbursement expense.
3. All services must have been incurred before you may request reimbursement from your Dependent Care Account. You cannot be reimbursed for services that were prepaid and not yet incurred.
4. Read the employee's certification for reimbursement on the front side of this form, then sign and date the form.
5. Claims will be processed within 10-12 business days, upon receipt (in our office) of all required documentation.
6. Submit this form and all required documentation to BFP Associates at the address on the front of this form.
7. This form is to be used to request reimbursement for Dependent Care Expenses.

In order to be reimbursed for Dependent Care expenses, you must complete the front side of this form, and attach 1 to this form:

1. Dependent Care

Dependent Care expenses must be itemized and must include the following;

- Type of service provided
- Date of service expense was incurred NOT PAID
- Dependent's name for whom the service was provided
- Provider who provided the service
- Provider address and telephone number
- Amount of expense

Types of evidence not acceptable for reimbursement

The following items are not acceptable as documentation for reimbursement under this plan:

- Credit card receipts
- Credit card statement
- Debit card receipts
- Debit card statement
- "Previous balance" or "balance forward" billing
- Cancelled checks
- Payment for services not yet incurred, but paid for