



# Flexible Spending Account Dependent Care Reimbursement

Please sign this form and either attach a signed receipt from a qualified care provider or have the care provider sign this form.

See instructions on reverse side.

<b>1. Employee Information</b>	Social Security Number - -	Name	Daytime Telephone Number ( )
	Address (include zip code) <input type="checkbox"/> Check if address is new		Home Telephone Number ( )

<b>2. Employer Information</b>	Employer Name	FSA Control Number
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<b>3. Dependent Information</b>	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ <b>Total Amount Submitted \$</b> _____			
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ <b>Total Amount Submitted \$</b> _____			
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ <b>Total Amount Submitted \$</b> _____			
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ <b>Total Amount Submitted \$</b> _____			

<b>4. Expenses for Before &amp; After Kindergarten</b>	Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ <b>Total Amount Submitted \$</b> _____			
<b>[Note] Review eligibility information on page two.</b>				

<b>5. Provider Information</b>	Provider Name	Social Security Number or Tax ID Number of Provider
	Relative <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address of Provider	Telephone Number of Provider ( )

**Cancelled checks are not adequate documentation unless services are provided by a relative.**

<b>6. Employee/Provider Certification</b>	<p>I certify that I have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account, and I further declare that I have not and will not claim credit for these expenses on my individual income tax returns.</p> <p>I further certify that I have read and understand the limitations on reimbursement from my Flexible Spending Account on the reverse side of this form for dependent care expenses, and that I am eligible to receive benefits under this program.</p> <p>I also certify that the above dependent care expenses are for the care of qualifying individuals and do not include separate charges for food, clothing, education, entertainment, activities, late fees, transportation or overnight care. <b>Please review eligibility information on page two.</b></p> <p>Signature of Employee _____ Date _____</p> <p><b>PROVIDER CERTIFIES</b> that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have actually been provided.</p> <p>Signature of Provider _____ Date _____</p>
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Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

## Instructions

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1. Complete all applicable sections.
2. If your claim submission is for more than four family members, please submit a separate claim form for each additional family member.
3. Use the Aetna Life Insurance Company's Automated Voice Response Unit (VRU) to obtain current account balance and claim payment information (this toll-free number is available from your employer). VRU is available Monday through Saturday, 7 a.m. to 12 midnight ET.
4. Items for which you are reimbursed cannot be claimed as deductions or credits on your federal income tax returns.
5. Send this completed benefits request form and documentation to the Aetna Life Insurance Company office that services your employer. This information can be obtained by contacting your employee benefits department.

## Eligibility

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1. Your expenses for dependent care services are eligible for reimbursement only if the services are performed for the benefit of a "qualifying individual." A qualifying individual is:
  - a dependent of yours who is under the age of 13
  - your spouse or dependent if he or she is incapable of self-care on a temporary or permanent basis
2. A "dependent" is someone you may claim as a dependent on your federal income tax return.
3. "Eligible dependent care services" include:
  - services for the care of a qualifying individual
  - in-home services that are related to the care of a qualifying individual

The expenses to be reimbursed must have been incurred to enable you or your spouse to remain gainfully employed during a period in which there was at least one qualifying individual residing in your household.

4. You cannot be reimbursed for expenses:
  - for service not yet received, even if paid in advance
  - incurred for transportation of a dependent to a dependent care center
  - paid to one of your dependents for whom an exemption is claimed on your tax return
  - paid to one of your children who is under the age of 19, even if not a dependent
  - for out-of-home care for a qualifying individual, over the age of 13, unless the qualifying individual spends at least eight hours per day in the employee's home
  - for kindergarten education (services provided for day care before or after school are eligible for reimbursement when listed separately)
5. If you use the services of a "dependent care center," the center must meet all requirements of state and local law. A "dependent care center" means any facility that provides care for more than six individuals (other than individuals who reside there) and receives a payment or grant for providing dependent care services.
6. If you are married, you will only be eligible for reimbursement of dependent care expenses if your spouse is also employed, looking for work, or if he or she is a full-time student or incapable of self-care.
7. You may not claim dependent care expenses that exceed the lesser of:
  - \$5,000, or \$2,500 if married and filing separate returns
  - your earned income
  - if you are married, your spouse's income (if your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have qualifying earnings for each month he or she is a full-time student or incapacitated. The amount of deemed earnings will be \$200 a month if you provide care for one qualifying individual or \$400 a month if you provide care for more than one qualifying individual).