Instructions

1. Employee must complete Employee Information.

2. Complete this Request for Reimbursement Form in its entirety. Please ensure your supporting documentation clearly indicates the requested amount. You must submit a claim for each reimbursement. You may not submit one claim at the beginning of the year for the entire plan year.

   Eligible expenses are defined in your Summary Plan Description. Such expenses include, but are not limited to after-school care, extended day programs, au pair services, babysitter in or out of the home, nanny day care expenses, sick child facility, and summer day camp for your qualifying child who is age 12 or under. Also eligible, custodial or elder day care expenses of a qualifying individual, educational expense for pre-school / nursery school, FICA / FUTA taxes of the dependent care provider.

   Ineligible expenses include but are not limited to airfare, living expenses or other fixed costs for a nanny or au pair, gardening services, kindergarten expenses, nursing home expenses, overnight camp expenses, meals, certain registration fees and educational expenses (tuition).

   NOTE: There is a special rule for children of divorced parents. The child is a qualifying individual of the "custodial parent", as defined in Code Section 152(e).

3. Check the appropriate box in Provider Certification. If both the employee and provider certifications are completed and signed, additional documentation is not required. For claim forms without the provider's signature, an itemized statement from the dependent care provider is required. Itemized statements should include the date(s) of service, the name and date of birth of the dependent, itemization of charges and the provider's name, address, and Tax ID/SS number. If mailing small receipts, we suggest you tape them to a standard size sheet of paper. However, faxing the claim will produce a quicker turnaround time.

4. Sign and date Employee Certification.

5. Submit reimbursement form and copies of supporting documentation to CONEXIS Flexible Benefits Services:

   By Fax: (888) 866-3312

   By Mail: P.O. Box 227197
   Dallas, TX 75222

Si necesita ayuda en español para entender este documento, puede solicitar sin costo adicional, llamando al número de servicio de cliente que aparece en la parte posterior de su tarjeta de identificación o en la parte inferior de la presente carta.

Employee Information

Employer Name _____

Employee Name _____ Account Number / SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ ZIP _____

Do you want to know if CONEXIS received and processed your claim? Please provide your e-mail address:

E-mail Address _____

Claim Information

Dependent Care Provider _____ Tax ID Number / SSN _____

Street Address _____ City _____ State _____ ZIP _____

Dependent Name	Date of Birth	Date(s) of Service (MM/DD/YYYY)		Requested Amount
		From:	To:	$
		From:	To:	$
		From:	To:	$
		From:	To:	$

Total Amount Requested* (Continue on additional page if necessary) $ _____

Provider Certification

_____ _____

Provider Signature Date

Provider's signature certifies dependent care services have been provided.

Please note that reimbursement of approved expenses will not be sent directly to your provider.

☐ My provider has signed the claim form.

☐ I have attached itemized receipt(s) or statement(s) from my dependent care provider.

Employee Certification

- I certify the expenses listed for reimbursement are eligible dependent care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan ("Plan");
- I certify the services listed above have been received by my qualifying individual (as defined in the Summary Plan Description);
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the dependent care expenses reimbursed may not be used to claim a deduction or credit on my federal income tax return;
- I agree to file IRS Form 2441 with my tax return and make reasonable attempts to obtain the care provider's tax identification number;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand any amount I receive over the statutory limits may not be excluded from my income and my maximum allocation may not exceed the earned income limitation as described in the Summary Plan Description;
- If my employer has adopted a grace period, I understand eligible expenses incurred and approved during a grace period will be paid first from any available amounts remaining in the plan year to which the grace period applies and then from the current plan year. If claims are submitted out of order, CONEXIS will provide a one-time reallocation at the end of the run-out period;
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I also understand failure to repay the Plan could result in adverse income tax consequences;
- By providing my e-mail address, I authorize CONEXIS to send account information to me via e-mail.

_____ _____

Employee Signature Date

* Only the "Amount Requested" will be paid, rather than the "Total Charges" for all "Date(s) of Service."

Fax: (888) 866-3312 Phone: (866) 279-8385