Dependent Care Flexible Spending Account Claim Form

Employee Information (PLEASE PRINT)

Employee Last Name | First Name | Middle

Social Security Number

Employer's Name | Employee ID # (if applicable)

E-mail Address ❑ I would like an e-mail confirming this claim has been received | Daytime Phone Number

For address changes, please contact your HR department.
Some of these claims have been previously submitted. ❑ Yes ❑ No

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Date(s) Service was incurred From	Through	Full Name of Dependent Receiving Service	Relationship to Employee	Age(s)	Amount Requested for Reimbursement
				Total Reimbursement Amount Requested	$

Provider Information

For expenses to be eligible, this section must be completed and signed by the Provider of dependent care services.
Total expenses incurred for services rendered to the individual(s) on the date(s) specified in the Dependent Care section above.

Provider Name | Tax I.D. # or Social Security #

Provider Signature | Date

Employee Certification

I hereby certify that the above information is correct; I have not received reimbursement previously for these expenses from any other plan; 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 less than $5,000; I have read the printed materials I have received describing this plan; I will retain a copy of this form and all original receipts for my records; and I am responsible for compliance with all applicable administrative processes; tax regulations and documentation. I understand that it is my responsibility to return any duplicate reimbursement received from any other sources to my account; I am responsible for any and all bank, savings or checking account charges that I incur; and expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

Employee Signature | Date

Mail this form and supporting documentation to:
HealthPartners Service Center
CDHP - Mail Route 21104T
P.O. Box 297
Minneapolis, MN 55440-0297

Or Fax to: **952-883-5026, 1-877-624-2287**

Questions: **Metro Area: 952-883-7000**
Outside metro: 1-866-443-9352
TTY line: 952-883-5127
www.healthpartners.com

Please retain a copy of this form and all attachments for your records.

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Dependent Care Flexible Spending Account
Claim Reimbursement Instructions

By signing and submitting this Dependent Care Reimbursement Form, you are certifying that expenses for which you request reimbursement satisfy all of the following conditions:

- If the reimbursement is for an eligible dependent, that dependent is under age 13, or otherwise meets the "Qualifying Person Test" as described in IRS Publication 503 (go to **irs.gov** to view IRS Publication 503).
- If the reimbursement is for care for your spouse, your spouse is physically or mentally incapable of self-care, and has the same principal abode as you for more than half the year.
- Reimbursements can be made only for services that have already been provided regardless of when they are billed or paid.
- Dependent care expenses must be provided to allow you and your spouse (if married) to work or actively look for work. Your spouse is considered working (i.e., gainfully employed) if, among other requirements, he or she is a full-time student at an educational organization, or physically or mentally incapable for self-care.
- Payments for dependent care cannot be made to you, your spouse, or someone you or your spouse claim as a tax dependent.
- Educational expenses incurred for a child in kindergarten and up are not reimbursable.
- Tuition is not a reimbursable expense; expenses must not be primarily educational in nature.
- Expenses such as activity fees (e.g., field trips, swim lessons, art class), books, supplies, transportation and meals are not reimbursable.

Supporting documentation must include the provider's tax ID number and the following:

1. Complete the claim form in full (Note: the provider must sign a substantiation for **each** claim.)

OR

2. Provide an itemized statement from the provider, including:
   a. the provider's name,
   b. your dependent's name and relationship to you,
   c. the dates services were provided, and
   d. the dollar amount of the services provided.

Documentation that **will not** be accepted to substantiate reimbursement includes, but is not limited to:

- Credit card receipts
- Cancelled checks
- Billing statement showing "previous balance", "balance forward", or "received on account"

Before submitting your dependent care reimbursement claim form

You can expedite your claim, by avoiding these common mistakes:

1. Be sure to sign and date the claim form.
2. Include the appropriate documentation to substantiate your expenses. If multiple items are on a receipt, circle the items for reimbursement (do not highlight the items).
3. Complete the claim form in full. Be sure that the supporting documentation equals the total you are requesting for reimbursement.
4. Please be sure to keep a copy of your claim form; any original receipts should not be sent but kept for your records.