



## Request for Reimbursement Dependent Care Spending Account

### *Instructions*

1. Employee must complete **Employee Information** – be sure to indicate if this is a new address
2. Complete **Claim Information** in its entirety. Please ensure that your supporting documentation clearly indicates the requested amount.  
**Eligible expenses** include but are not limited to After-school care of extended day program for a child <13, Au pair for a child <13, babysitter in or out of the home for a child <13, custodial or elder day care expenses of a qualified dependent, disabled spouse or tax dependent day care of a qualified dependent, educational expenses for pre-school / nursery school, FICA / FUTA taxes of the day care provider, nanny day care expenses for a child <13, sick child facility for a child <13, summer day camp for a child <13.  
**Ineligible expenses** include but are not limited to: Assisted living expenses, airfare, living expenses or other fixed costs for a nanny or au pair, gardening services, housekeeping services, kindergarten expenses, nursing home expenses, overnight camp expenses, transportation expenses, meals, registration fees and educational expenses (tuition).
3. Check the appropriate box in **Provider Certification**. If the provider signs the claim form, additional documentation is not required. If not signed, attach an Itemized Statement, receipt or bill from your day care provider including: Provider, Information, Dependent name, Date(s) of service, and Itemization of charge(s). When attaching small receipts, we suggest you tape them to a standard size sheet of paper
4. Sign and date **Employee Certification**
5. **Submit Claims To:**  
 CONEXIS Cafeteria Plan Services  
 P.O. Box 227197  
 Dallas, Texas 75222  
 Fax: (888) 866-3312 Phone: (866) 279-8385

### *Employee Information*

Employer Name \_\_\_\_\_  Check here if this is a new address  
 Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Street Address \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### *Claim Information*

Name of Day Care Provider \_\_\_\_\_ Tax ID Number / SSN \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dates of Service \_\_\_\_\_ Through \_\_\_\_\_ Total Charges \$ \_\_\_\_\_

Dependent Name	Date of Birth	Date(s) of Service (MM/DD/YYYY)	Requested Amount
_____	_____	From: _____ To: _____	\$ _____
_____	_____	From: _____ To: _____	\$ _____
_____	_____	From: _____ To: _____	\$ _____
_____	_____	From: _____ To: _____	\$ _____
<b>Total Amount Requested (continue on additional page if necessary)</b>			<b>\$ _____</b>



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*Provider Certification*

I certify that the above services have been provided.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

- If the provider signs the claim form, additional documentation is not required
- My provider has signed the claim form
  - I have attached itemized receipt(s) or statement(s) from my day 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. I also certify the services listed above have been received by my dependent. 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 the dependent care expenses reimbursed cannot 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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date