

### *Instructions*

1. Employee must complete **Employee Information**.
2. Complete **Claim Information** 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 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, meals, 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 Claims to CONEXIS Flexible Benefits Services:**

**By Fax:** (888) 866-3312

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

**Employee Information**

Employer Name \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Account Number / SSN \_\_\_\_\_  
 Street Address \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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 Code \_\_\_\_\_

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*</b> (Continue on additional page if necessary)			\$ _____

**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 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 the grace period will be paid first from available amounts that were remaining at the end of the plan year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current plan year. I also understand claims will be paid in the order in which they are received and previous claims will not be reprocessed or re-characterized so as to change the order in which they were received;
- 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."