USBA*flex*

REQUEST FOR REIMBURSEMENT CLAIM FORM

860 East 9085 South
Sandy, Utah 84094
877-USBA125 * Fax 866-872-2125

Employer Name:			
Employee Name:	Last First MI	**SS#:**	
Address:	Street City State ZIP	**PHONE :**	( )

☐ **Please check if this is a new address**

Please read the back of this form for Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

<u>* Information below must be completed. Provider's may sign the below affidavit to certify the amount and date of expenses incurred, if no receipt is available.</u>

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
						Total:	$

AFFIDAVIT OF DEPENDENT CARE SERVICES RENDERED

I have provided adult/child care for the above named dependent for those dates and expenses identified for reimbursement above.

Signature of Care Giver________________________________ **Date**_________/_________/_________

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement or claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: ____ **Date:** ________ /________ /________

Account Rules and Claim Filing Instructions

Rules for Dependent Care Accounts

1. You cannot submit a claim unless you are participating in the Cafeteria Plan.
2. You can be reimbursed only for eligible expenses occurring during the coverage period in which your contributions are made.
3. You can submit a claim at any time during the plan year and for a specified period after the plan year as described in the Summary Plan Description.
4. If you terminate employment, you can submit a claim for a specified period after the date of termination if so stated in the Summary Plan Description as long as the service occurred before your date of termination.
5. IRS rules stipulate that any money left in the account(s) after all reimbursements for the plan year have been processed cannot be carried forward or returned. Money in one account cannot be used for expenses incurred in another account. For instance, any unused amounts left in the medical account cannot be used to reimburse dependent care expenses.
6. You cannot receive payment from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expenses.
7. If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.
8. You cannot bill for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year covering the period during that plan year.
9. Complete ALL the information on the claim form for each amount claimed for reimbursement.
10. Attach copies of receipts from service providers to the claim. DO NOT ATTACH COPIES OF CHECKS AS RECEIPTS.
11. Sign and date the claim.
12. Make a photocopy of the claim for your records.
13. Submit the claim with attached receipts according to the procedures provided.

Dependent Care Expenses

1. You can use a Dependent Care Spending Account only if you pay dependent day care expenses to be able to work. Your day care services can take place either inside or outside of your home. If you are married, your spouse must also work, go to school full time, or be incapable of self-care for you to be eligible.
2. Only (a) dependents under the age of thirteen or (b) dependent adults or children thirteen years or older who are mentally or physically incapable of self-care are covered.
3. Your Maximum Contribution Amount cannot be more than the smaller of (A) or (B).
   - A- Your income or your spouse’s income, whichever is smaller. If your spouse is a full-time student or incapable of self-care, your spouse is considered to earn $2,400 per year with one dependent or $4,800 per year with two or more dependents.
   - B- $5,000 per year if your tax filing status is married filing jointly and or single head of household or $2,500 per year if your tax filing status is 'married filing separately'.
4. You cannot claim expenses if the service provider is your child or stepchild and are under age 19 or if you claim the service provider as a dependent for Federal income tax purposes.
5. To be reimbursed, you must include the facility’s name, address, and tax identification number or the Social Security number of the individual providing the dependent day care service.
6. The maximum amount you can be reimbursed during the time you are covered in the Plan Year cannot exceed the salary reduction amounts you have elected and made under the Dependent Care Assistance Plan less any previous reimbursements paid.

Internal Revenue Service Publication 502 lists the eligible tax-free expenses. An Eligible expense means any item for which you could have claimed a medical expense deduction on an itemized Federal income tax return (except insurance premiums, long-term care and other similar charges) and is not eligible under your medical or any other source. You or your dependents while participating in the plan must incur the expenses.