ADP National Account Services
ProBusiness Division

Dependent Care Reimbursement Account

For additional forms, a listing of reimbursable expenses and other helpful information, please visit our web site at http://www.probusiness.com.

PLEASE COMPLETE WHEN FAXING

Date:____________________

# of Pages:____________________

Return Fax#:____________________

TOTAL AMOUNT OF REIMBURSEMENT REQUESTED $ _ , _ _ _ . _ _

Participant's Signature ________________________ Date ___ / ___ / ___
(REQUIRED)

I certify that all listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source. Additionally, I certify that I have read the reverse side of this reimbursement form and the expenses listed meet all of the IRS guidelines.

Participant Information

Name: Last ______ First ______ MI ___ Employer: ____________

SSN: _ _ _ - _ _ - _ _ _ _ E-Mail Address: ____________

Home Address: ________________________
Street Address City State Zip

Daytime Phone: ( ) ____________ ☐ Check if this is a change in address

Helpful Hints To Ensure An Expedited Reimbursement

IRS regulations require services to have been rendered in order to be reimbursable. Therefore, we are unable to issue reimbursement for services that have not been provided. The care provided must be for your dependent under the age of 13 or for your incapacitated dependent or spouse who is unable to care for himself/herself. Additionally, the following services are NOT reimbursable under your dependent care account:

- Registration Fees
- Lessons
- Late Payment Fees
- Meals
- Overnight Camp Expenses
- Educational Expenses
- Transportation Expenses

Reimbursement Guidelines

Please have your day care provider sign below in the "Provider Signature" section. If your provider does not sign in the "Provider Signature" section you must attach a bill or receipt showing **ACTUAL DATES OF SERVICE** (not the date that you paid the provider), **Cost,** and the **Care Provider's Tax ID** or **Social Security Number**.

Provider Certifies: That I am a qualified care provider as defined by the Internal Revenue Code, and that the expenses for services claimed below have actually been provided.

Provider's Signature ________________________ Date ____________

Beginning Date of Service	**Ending Date of Service**	**Providers Name**	**Providers Social Security or Tax ID#**
Month / Day / Year	Month / Day / Year		

Dependents Date of Birth	**Name of Dependent**	**Grade**	**Disabled Y/N**	**Amount Requested**
Month / Day / Year				$ _ , _ _ _ . _ _

Beginning Date of Service	**Ending Date of Service**	**Providers Name**	**Providers Social Security or Tax ID#**
Month / Day / Year	Month / Day / Year		

Dependents Date of Birth	**Name of Dependent**	**Grade**	**Disabled Y/N**	**Amount Requested**
Month / Day / Year				$ _ , _ _ _ . _ _

Fax this completed Dependent Care Spending Account Reimbursement Form and supporting documentation to: 1-800-269-5231 or mail to ADP National Account Services, ProBusiness Division, PO Box 3001, Bothell, WA 98041-3001 (if you fax, please do not send the hard copy via mail). If you have questions regarding your account, please call the Employee Services Center at 1-800-269-0020 or e-mail us at bsa@probusiness.com.

Dependent Care Reimbursement Account: Claim Certification

For The Dependent Care Reimbursement Account:
I certify that I utilized care as specified and I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for qualifying individuals. I understand the limit for actual deferrals and reimbursements will not exceed the lesser of my own income or the earned income of my spouse, or $5,000 during any calendar year period. If my spouse is a full-time student at least 5 months in the year or is incapable of self-care, then my spouse will be considered to have earned $250 per month if one dependent is receiving care or $500 per month if two or more dependents are receiving care. Neither my spouse nor myself can claim a dependent exemption for the provider of care. The care provided was for my dependent under the age of 13 or for my physically or mentally incapacitated dependent or spouse who was unable to care for himself/herself.

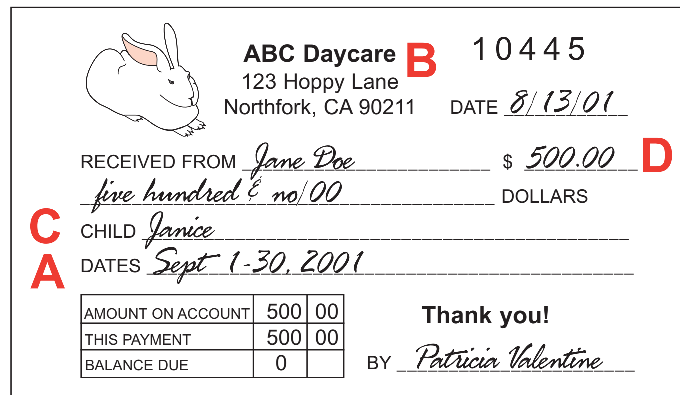
Helpful Claims Information & General Submission Tips:

✓ All claims must be made on a signed, fully filled-out and itemized claim form. **Please note that upon receipt of an unsigned or incomplete claim form, a letter will be sent requesting that the participant sign or complete the form before processing.**

✓ **TIMELY SUBMISSION OF CLAIMS.** If you wait until the end of the grace period (as detailed in your company's Plan Document/Summary Plan Description) to submit your claims, you run the risk of forfeiture of any unused dollars if your claim does not include all the required documentation. Any new claims or documentation submitted after the grace period cannot be considered.

✓ **FAX TIPS AND TRICKS.** Please print information using black ink to ensure readable transmission. If the documents are faint, highlighted, or distorted, they will not transmit clearly and may not be readable when we receive them. If the transmitted documents are not readable, a letter will be sent requesting legible documentation.

E X A M P L E



ABC Daycare B
123 Hoppy Lane
Northfork, CA 90211

10445

DATE 8/13/01

RECEIVED FROM Jane Doe $ 500.00 D
five hundred & no/00 DOLLARS
C CHILD Janice
A DATES Sept 1-30, 2001

AMOUNT ON ACCOUNT	500	00
THIS PAYMENT	500	00
BALANCE DUE	0	

Thank you!
BY Patricia Valentine

Beginning Date of Service	A Ending Date of Service	B Providers Name	Providers Social Security or Tax ID#
__ __ / __ __ / __ __ (Month / Day / Year)	__ __ / __ __ / __ __ (Month / Day / Year)		

Dependent s Date of Birth	C Name of Dependent	Grade	Disabled Y/N	D Amount Requested
__ __ / __ __ / __ __ (Month / Day / Year)				$ __ , __ __ __ . __ __

Reimbursement Submission Tips
The above example details the required information contained on a typical provider receipt. Please note that the DATE OF SERVICE is not the date the charge was paid, but the date span encompassing the dates service was actually rendered. Additional information required for processing, which is often not found on the third party documentation includes: Provider Social Security or Tax Identification Number, Dependent's Date of Birth and Grade Level. Please verify that all fields are filled out to assure prompt processing.