Spending Accounts by WageWorks

REIMBURSEMENT FORM – DEPENDENT CARE EXPENSES

Use only CAPITAL LETTERS, completely fill in ovals, and don't use red ink.

FAX TO: 1-866-643-2219 TOLL FREE

For additional expenses, please use next page.

ZDZCZRZ

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

FOR WageWorks ONLY

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR DEPENDENT CARE EXPENSES

EXPENSE 1

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN (ENTER ALL 9's IF TAX-EXEMPT)

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

RECEIPT ATTACHED? ◯ YES ◯ NO

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #3 NAME _____

AFFIDAVIT:

Your day care provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.

I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____

SECTION 3: CERTIFICATION

Please read Certification Statement thoroughly before signing.

I hereby certify that:

- I have read and understand the instructions on page one.
- The information contained within this form is correct.
- I have not received reimbursement previously for these expenses from my Flexible Spending Account or any other plan and will not seek reimbursement by any other plan.
- The total of any reimbursed dependent day care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Reimbursement of dependent day care expenses will reduce and may eliminate completely my ability to claim a dependent day care credit on my personal income tax return.
- Dependent day care expenses reimbursed through this account cannot be used as a dependent day care credit on my personal tax return.

I hereby authorize release of payment through my Flexible Spending Account.

I hereby authorize WageWorks or its representatives to obtain necessary information from all dependent day care providers and other agencies or organizations to consider the claim for reimbursement under my Flexible Spending Account.

FAX: 1-866-643-2219 Toll Free

MAIL:
WageWorks Spending Accounts
PO Box 34700 Louisville, KY 40232

PHONE: 1-800-678-6684

Date (MMDDYY)

Employee Signature _____

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USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

USE THIS PAGE FOR ADDITIONAL DEPENDENT CARE EXPENSES.

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SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

SECTION 5: YOUR ADDITIONAL DEPENDENT CARE EXPENSES

EXPENSE 2

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN (ENTER ALL 9's IF TAX-EXEMPT)

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

RECEIPT ATTACHED? ◯ YES ◯ NO

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #3 NAME _____

AFFIDAVIT:
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I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____

EXPENSE 3

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN (ENTER ALL 9's IF TAX-EXEMPT)

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

RECEIPT ATTACHED? ◯ YES ◯ NO

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #3 NAME _____

AFFIDAVIT:
Your day care provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.
I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____