Dependent Care Reimbursement Account ClaimForm

Employee: _____ SSN: _____

Home Address: _____ Day Time Phone: **( )** _____

Employer: _____ Email: _____

❑ **PLEASE CHECK BOX IF ANY OF THE ABOVE INFORMATION HAS CHANGED.**

You must provide proof of having incurred each expense. The providers signature on this form fulfills the need for proof of these expenses. Please see the pamphlet, "Are your Dependent Care Expenses ELIGIBLE for the Dependent Care Reimbursement Account?, " for complete information of eligible expenses, dependents and types of care. This form must be complete in order for a claim to be valid for reimbursement. Incomplete forms cannot be processed. PLEASE MAKE A COPY OF THIS FORM AND YOUR RECEIPTS FOR YOUR PERSONAL TAX RECORDS. Expenses may not exceed the lesser of your earned income or your spouses earned income, if you are married. If your spouse is a full-time student, or incapable of self care, and has no earned income, your expenses may not exceed $2,400 a year if your are providing care for one dependent or $4800 a year if you are providing care for two or more dependents.

Name of Dependent: _____

Age of Dependent: _____

Period Covered: From: _____ Through: _____

Amount Paid For Above Dates: $ _____

Care Providers Tax ID or Social Security Number: _____

Care Providers Name: _____

Care Providers Address: _____

Signature of Care Provider:

No Receipt Necessary if the signature of your care provider is included.

I certify that the above information is correct and complete. I am requesting reimbursement for eligible expenses incurred during the plan year (while I was a participant). I have actually incurred these expenses and will not seek reimbursement for them by any other plan or program of any employer or other person. I also understand that I am responsible for any tax consequences, which may result from the reimbursement of these expenses from this plan.

Participant Signature: _____ Date: _____

For TLC Use Only

Account	Dates of Service	Total Amount	Pending Amount	Reason Pending	Initial

Submit Claims By:
FAX: (510) 795-0858
Or
Mail: 3340 Walnut Ave #290
Fremont, CA 94538

Contact Information:
*Online Account Info.....https://www.myrsc.com
*Customer Service Rep....(800) 533-0113 x 606
*Email us at.....flex@lipman.com