Dependent Care Account

Reimbursement Request Form

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Phone Number (_____) _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

If Your Provider Gives You A Receipt: Complete this section, and attach a copy of the receipt.

Claimant Name	Date of Care Start Date (within a single Plan Year)	Date of Care End Date (within a single Plan Year)	Provider	Amount	Claim Ref #
					01
					02
					03
					04

OR

If Your Provider Does Not Provide You With A Receipt: Have your Provider complete this section.

Provider Name: _____

Address: _____

City, ST, ZIP: _____

Tax Payer ID/SSN: _____

Dependent Care for (Name and Age):_____

Dates of Care (within a single Plan Year) Start Date: _____ End Date: _____

Amount Charged: $_____

Provider Signature: _____ Date: _____

Participant Authorization—By submitting this form to Lifetime Benefit Solutions, I certify that the information here is true and correct.

- I authorize the above expenses to be reimbursed from my dependent care account.
- I certify the expenses qualify as valid dependent care expenses under the terms of the Plan.
- I understand that the copy of my receipt will include Provider name, address, tax ID/SSN, child's name and age, dates of care, and amount charged.
- I will keep copies of all documents submitted to Lifetime Benefit Solutions, for my own personal records; Lifetime Benefit Solutions, is not responsible for retaining copies of my receipts beyond the current Plan year.
- I understand a qualifying dependent is a child under age 13, who is claimed as a dependent on my federal income tax return (special rules apply for divorced parents), a disabled spouse, and any other dependent on my tax return who resides in my home and is physically or mentally disabled.
- I certify these expenses have not previously been reimbursed and I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit.
- I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification number.

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 6509, Syracuse, NY 13217 or
- **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.