HIGHMARK Delaware

Dependent Care Flexible Spending Account Claim Form

INSTRUCTIONS:
1. Please see the reverse side for Employee Certification and Definitions and Special Rules.
2. Please **PRINT** all requested information and be sure to **SIGN reverse side**.
3. Please retain a copy of this completed form and documentation for your records.

PAYMENT OR REIMBURSEMENT OF DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS ARE SUBJECT TO THE PROVISIONS OF YOUR EMPLOYER'S PLAN DOCUMENTS AND APPLICABLE LAWS AND REGULATIONS.

Employee's Name - Last, First, Middle Initial	**Employee's Social Security Number**	**Martial Status** ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Address ❑ Check this box if this is a new address.		**If you checked married, is your spouse employed?** ❑ Yes ❑ No
Daytime Telephone Number - Include Area Code	**Employer**	

- Please submit this form to request reimbursement for claims for dependent day care/household services after the expense has been incurred and the service period has ended.
- Either the provider must complete the Provider Information and Certification Section below or you must attach documentation from the provider.

  Separate documentation must include the following:
  - Provider's complete name.
  - Provider's taxpayer identification number, unless it is a tax-exempt organization. For an individual, it is the individual's social security number or taxpayer identification number. For an organization, it is the organization's employer identification number. For a tax-exempt organization described in Internal Revenue Code section 501(c)(3), such as a school or church, write "tax-exempt" in the space provided.
  - Provider's address including street address, city, state, and zip code.
  - Provider's daytime telephone number, including area code.
  - Employee's name.
  - Name of dependent for whom care/household services were provided.
  - Service period including beginning and ending dates.
  - Amount provider received for services.
  - Type of services—whether dependent day care or household services.
- If you have any questions:
  Visit: highmarkbcbsde.com, Select *Pre-Tax Benefits Program*
  Email: Flex@bcbsde.com
  Call: 302.421.8970 or 800.559.FLEX (3539), 8:00 am-5:00 pm (ET)
  Fax: 302.421.8883

FULL NAME OF DEPENDENT FOR WHOM CARE WAS PROVIDED	DEPENDENT'S SOCIAL SECURITY NUMBER	DEPENDENT'S BIRTH DATE	RELATIONSHIP TO EMPLOYEE	DATES OF CARE FROM	DATES OF CARE TO	REIMBURSEMENT REQUEST AMOUNT
		/ /		/ /	/ /	$
		/ /		/ /	/ /	
		/ /		/ /	/ /	
		/ /		/ /	/ /	
				Total Reimbursement Requested:		$

PROVIDER INFORMATION AND CERTIFICATION SECTION

Provider's Name	**Taxpayer Identification Number**	**Amount Received for:** Day Care Services: $ _____ Household Services: $ _____
Provider's Address	**Daytime Telephone Number**–Include Area Code	

I certify that:
- For the claim shown above, I provided the services for dependent day care or household services for the person listed on the dates shown.
- I have received the amount indicated in the space labeled "Amount Received for Day Care/Household Services."
- I am providing my IRS taxpayer identification number in the space labeled above, unless I am a tax-exempt organization. If I am an individual, my taxpayer identification number is either my social security number or my individual taxpayer identification number. If I am an organization, then it is my employer identification number. If I am a tax-exempt organization described in Internal Revenue Code section 501(c)(3), such as a school or church, I have written "tax-exempt" in the space provided for the taxpayer identification number.
- If I am a dependent day care center, (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations, including licensing requirements.

Provider's Signature: _____ **Date:** _____/_____/_____

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a claim containing any false, incomplete or misleading information may be guilty of a felony.

PLEASE READ AND SIGN REVERSE SIDE.

EMPLOYEE CERTIFICATION SECTION

I certify that I have met all of the following requirements for the claims submitted for expenses incurred during the plan year. (See below for Definitions and Special Rules.)

1. I incurred the expenses to enable me (and my spouse, if married, unless my spouse is physically or mentally incapable of caring for himself or herself or a full-time student) to be **gainfully employed** or to look for gainful employment. Expenses incurred while I am (or my spouse is, if married) not at work (because of illness, vacation, etc.) do not count as work related expenses, unless the absence is a "short" or "temporary" absence and I am required to pay for care on a weekly or longer basis.

2. I incurred the expenses for the care of, or household services related to, a Qualifying Individual who is either **(a)** a dependent under age 13 or whom I am the custodial parent and who may be claimed as an exemption on my federal income tax return for the current tax year, **(b)** my spouse who is physically or mentally incapable of caring for himself or herself and who resides in my household for more than one-half of the year or **(c)** any other relative or household member (regardless of age) who is physically or mentally incapable of caring for himself or herself, who is principally dependent on me for support and who resides in my household for more than one-half of the year. ***(See special rules that are applicable in certain circumstances where a noncustodial divorced or separated parent is entitled to claim the child as a dependent.)***

3. If I incurred the expenses for services outside of my household, they are incurred for the care of a dependent who is described in 2(a) above, or for the care of a spouse or other tax dependent who is described in 2(b) above **and** who regularly spends at least 8 hours per day in my household.

4. If I incurred the expenses for services provided at a **dependent day care center** (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations, including licensing agreements.

5. If the services were performed by an individual, the expenses were not paid or payable to a child of mine who is under age 19 by December 31, or to an individual for whom I (or my spouse, if married) can claim as a dependent for the current tax year.

6. The expenses claimed have not been paid or reimbursed by, and have not been and will not be submitted for payment or reimbursement by, another employer's dependent care flexible spending account.

7. I will not claim a dependent care tax credit or any other credit on my federal income tax return for any expense reimbursed under this plan.

8. I certify that my pre-tax contribution ot the Dependent Care FSA will not exceed the **least** of the following limits: **(a)** $5,000 ($2,500 if I am married and do not file a joint federal income tax return with my spouse for the current tax year); **(b)** My taxable compensation for the year (after my pre-tax contribution to the dependent care spending account); **(c)** If I am married at the end of current tax year, my spouse's taxable compensation (after his or her pre-tax contribution to any dependent care spending account). For purposes of this section, my spouse will be deemed to have taxable compensation of $250 ($500 if I have 2 or more dependents described in paragraph 2 above), for each month in which my spouse is **(i)** physically or mentally incapable of caring for himself or herself, or **(ii)** a full-time student at an educational institution.

9. Provider Information: If a correct and complete name, address and taxpayer identification number of the person or **dependent day care center** performing the dependent care services are not shown in the provider information section of this claim form, on separate documentation attached to this claim form, or on IRS **Form W-10 Dependent Care Provider's Identification and Certification**, it is because of one of the following reasons **(check one):**

- ❑ I submitted information for this provider on a previous claim earlier in this plan year; or
- ❑ I am not required to obtain the taxpayer identification number because the provider is a tax-exempt organization under Section 501 (c)(3) of the Internal Revenue Code (such as a church or school); or
- ❑ I requested this information from the provider but the provider did not comply with my request.

10. I agree to notify the Benefits Department of my employer if I have any reason to believe that any expense for which I have obtained reimbursement is not a qualifying dependent care expense. If requested by my employer, I also agree to indemnify and reimburse my employer for any liability it may incur for failure to withhold federal and state income tax and/or Social Security and Medicare tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

11. My employer may limit my reimbursement in the event it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

Employee's Signature: _____ **Date:** _____/_____/_____

DEFINITIONS AND SPECIAL RULES

***Eligible care* only includes the cost of services for the individual's well-being and safety.** Amounts paid for the cost of items other than the care of your spouse or dependent (such as food, and schooling for a child prior to kindergarten) may be included **only** if the items are incidental to the care of the individual and cannot be separated from the total cost. Do not include: the cost of: **(i)** clothing, **(ii)** entertainment, **(iii)** sending your dependent to an overnight camp, or **(iv)** schooling for a child in kindergarten and above.

Gainfully employed means that I am working for an organization for wages either full-time or part-time and my spouse, if married, is either working for an organization for wages, or in his or her own business or partnership, either full-time or part-time. Neither I am (nor my spouse, if married) is gainfully employed if I do or he/she does unpaid volunteer work or volunteer work for a nominal salary.

Household Services are services needed to care for the person as well as to run the home. Examples are the services of a cook, maid, babysitter, housekeeper, or cleaning person if the services were partly for the care of the individual. Do **not** include services of a chauffeur or gardner.

Special Rules that are applicable in certain circumstances where a noncustodial divorced or separated parent is entitled to claim the child as a dependent.

If I am divorced, legally separated, or live apart from my spouse during the last six (6) months of the current tax year, I can treat my child as a Qualifying Individual even if I cannot claim my child as a dependent for the current tax year, **if all five (5) of the following are true: (a)** I have or had custody of the child for a longer time in the current tax year than the other parent; **(b)** I or both parents provide more than half of the child's support for the current tax year; **(c)** I or both parents have or had custody of the child for more than half of the current calendar year; **(d)** The child was under age 13 or was disabled and could not care himself or herself; **and, (e)** The other parent claims the child as a dependent for the current tax year because: **(i)** As the custodial parent, I signed IRS Form 8332, Release of Claim to Exemption for Child of Divorced or Separated Parents, or a similar statement agreeing not to claim the child's exemption for the current tax year; **or (ii)** My divorce decree or written agreement went into effect before 1985 and it states that the other parent can claim the child as a dependent, **and** the other parent gave at least $600 for the child's support in the current tax year. **This rule does not apply if** my decree or agreement was changed after 1984 to say that the other parent cannot claim the child as a dependent.

Attach copies of the required documentation to this form and send to:

Highmark Blue Cross Blue Shield Delaware
Flexible Benefits Department
P.O. Box 8737
Wilmington, DE 19899-8737