Recurring Dependent Care Flexible Spending Account Claim Form

PLEASE PRINT

Name _____ Social Security #_____

Address _____ Employer_____

_____ Daytime Phone _____

❑ Please check box for change of address

Instructions for requesting recurring reimbursement

- Complete this form, making sure that it is signed and dated below.
- Attach supporting documentation or have your provider complete the section below. **Documentation must show nature and amount of expense plus date incurred. Documentation will not be returned; therefore, it is advised that you keep copies of your submissions.**
- **Payments will be made directly to you; they cannot be assigned to the provider of services.**

NOTE: IF YOUR COST OF DEPENDENT CARE PER MONTH IS LESS THAN YOUR MONTHLY PAYROLL DEDUCTIONS, OR YOU HAVE CURRENTLY CONTRIBUTED MORE TO YOUR PLAN THAN YOU HAVE INCURRED IN EXPENSES, YOU DO NOT QUALIFY FOR RECURRING DEPENDENT CARE AND YOU WILL NEED TO FILE CLAIMS AS SERVICES ARE INCURRED.

❑ **Start Recurring DCA:** Please start my recurring reimbursement with the information provided below.

Dependent's Name	**Relationship to Participant**	**Dates of Service** (Must be within current plan year)	**Cost of Service**	**Occurrence (Weekly, Semi-Monthly, or Monthly)** NOTE: HOURLY CLAIMS CANNOT BE SET-UP AS RECURRING
		to		
		to		
		to		
❑ **Change recurring DCA information:** Please update my recurring reimbursement with the information provided above as of the provided effective date.				Effective Date:
❑ **Stop Recurring DCA:** Please update my recurring reimbursement with the information provided above as of the provided effective date.				Effective Date:

Provider's Name and Tax ID or Social Security Number	**Provider's address**	**Provider's Signature**	**Date**

I verify that I make regular payments to the Dependent Care provider described above for the dependents named above. I authorize LD&B Benefits Administrators to automatically reimburse me the amount stated above from my Dependent Care Flexible Spending Account. I agree that if the amount changes or if, for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will notify LD&B Benefits Administrators immediately in writing. This form is valid for only the current plan year or until the contracted rate described above changes, whichever term is less*. I understand this form is not valid unless signed by my Dependent Care provider. I understand the right to submit claims via this program may be discontinued at any time. I understand that the rules and regulations that govern Flexible Spending Accounts are a matter of law and are strictly enforced by the Internal Revenue Service (IRS). I understand that hourly services cannot be set-up as recurring.

Signature _____ **Date** _____

* If the contracted rate with your provider changes, a new form must submitted. A new form must be submitted each plan year even if the contracted rate does not change.

Attach supporting documentation and return to:

Mail to: **LD&B Benefits Administrators**
205-C South Liberty Street
Harrisonburg, VA 22801

Fax to: **540.438.4133 / 866.292.8331**
Phone support: **540.437.1425 / 877.532.5478** M – F 8:00 – 5:00 EST
Secure upload at: **www.LDBbenefitsadmin.com**

Dependent Care Expenses

Dependent care expenses that allow you (and your spouse if you are married) to be gainfully employed are eligible. Note that if you (or your spouse if you are married) are not employed, you must either be actively seeking employment or be a full-time student in order to claim dependent care expenses. Care that is primarily for medical or an educational (i.e. kindergarten) purpose is not eligible.

Eligible Dependents

- Dependent children under age 13
- A spouse or other dependent who is incapable of caring for himself or herself and whose principal residence is your home

Care Providers

- If care is provided outside the home in a "dependent care center," the center must comply with all applicable laws and regulations of the state (or unit of local government) in which located. A "dependent care center" is a facility that provides care for more than six nonresident individuals, and receives a fee, payment, or grant for providing such services.
- Care can also be provided outside the home if the provider cares for fewer than seven nonresident individuals. In this situation, compliance with applicable laws and regulations of the state (or unit of local government) is not required.
- The employee's dependents and children of the employee under age 19 are not eligible dependent care providers.

For more information on eligible dependent care expenses, see IRS publication 503, "Child and Dependent Care Credit," available from your local IRS office.

The maximum reimbursement from this plan and any other dependent care plan for which you may be eligible is $5,000 per year ($2,500 if you are married filing separately). Reimbursement is further limited to the "earned" income of the lower earning spouse. In general, earned income means income from employment such as wages, salaries, and tips. If your spouse is a full-time student or incapable of caring for himself or herself, you may assume an earned income of $200 per month for one qualifying dependent or $400 per month for two or more qualifying dependents.

Contributions can be used only for reimbursement of expenses incurred during that plan year starting on your participation date. Expenses are incurred on the date services are provided. Any balance in your account after the claim submission cut-off date for a plan year will be forfeited. Dependent care expenses reimbursed through the plan cannot be applied toward the dependent care tax credit. Maximum expenses for the tax credit calculation are reduced, dollar for dollar, by the amount of expenses reimbursed through this plan.

PLEASE NOTE: Inappropriate, unacceptable documentation includes cancelled checks, balance forward or balance due receipts, and payment on account receipts that do not include date range of rendered services.