34077

CONEXIS human resourceful®

University of California
Dependent Care Claim Form

CONEXIS Account Number _____ **or** **Social Security Number** ___ - __ - ____

First Name _____ **Last Name** _____

Dependent Care Provider Name _____ **Provider Tax ID Number or SSN** _____

Provider Street Address _____ **Provider City** _____ **State** __ **Zip Code** _____

Dependent Name / Date of Birth	Care Start Date (MM/DD/YY)	Care End Date (MM/DD/YY)	Requested Amount
	__/__/__	__/__/__	$,.
	__/__/__	__/__/__	$,.
	__/__/__	__/__/__	$,.
Dependent Name / **Date of Birth**	**Care Start Date (MM/DD/YY)**	**Care End Date (MM/DD/YY)**	**Requested Amount**
	__/__/__	__/__/__	$,.
	__/__/__	__/__/__	$,.
	__/__/__	__/__/__	$,.

☐ My provider has signed the claim form. (additional documentation is not required)

$,. **Total Amount Requested**

Provider Certification

Provider Signature: I certify that the above services have been provided. **Date**

☐ I have attached documentation from my dependent care provider showing dependent name(s), services provided, dates of service, and cost.

Employee Certification

- I certify the expenses listed for reimbursement are eligible dependent care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan ("Plan");
- I certify the services listed above have been received by my qualifying individual (as defined in the Summary Plan Description);
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the dependent care expenses reimbursed may not be used to claim a deduction or credit on my federal income tax return;
- I agree to file IRS Form 2441 with my tax return and make reasonable attempts to obtain the care provider's tax identification number;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand any amount I receive over the statutory limits may not be excluded from my income and my maximum allocation may not exceed the earned income limitation as described in the Summary Plan Description;
- If my employer has adopted a grace period, I understand eligible expenses incurred and approved during a grace period will be paid first from any available amounts remaining in the plan year to which the grace period applies and then from the current plan year. If necessary, claims may be reassigned after the run-out period has expired.
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I also understand failure to repay the Plan could result in adverse income tax consequences.

Employee Signature **Date**