University of California

Request for Reimbursement

Dependent Care Flexible Spending Account

Employee Information

Account Number OR **Social Security Number** ___ – __ – ____

First Name

Last Name

Dependent Care Provider

Dependent Care Tax ID / SSN

Provider Street Address

City

State

Zip

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

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

TOTAL AMOUNT REQUESTED (Include additional forms if necessary) $.

Provider Certification

Provider Signature **Date**

Provider's signature certifies dependent care services have been provided on the dates listed above.

I have included:

- ☐ Provider's signature above, **OR**
- ☐ Itemized receipts/statements from the dependent care provider; this documentation has the start and end dates of service, the dependent's name, description of service (day care, preschool, etc.) and the provider's name and address.

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 claims are submitted out of order, WageWorks will provide a one-time reallocation at the end of the run-out period;
- 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.
- By providing my e-mail address, I authorize WageWorks to send information to me via e-mail.

Employee Signature **Date**

Web: https://mybenefits.wageworks.com **Claims Fax: (800) 482-4174** Phone: 1-800-482-4120