



# FLEXIBLE SPENDING ACCOUNT DEPENDENT CARE EXPENSE CLAIM FORM

FAX TO: 303-221-2785

IT IS NOT NECESSARY TO INCLUDE A COVER SHEET

## PLAN & EMPLOYEE INFORMATION

Check here if you have an address or name change

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ PLAN YEAR: \_\_\_\_\_

## DEPENDENT CARE EXPENSES

\*\*\*\*\*PLEASE DO NOT HIGHLIGHT ITEMS ON THIS FORM IF YOU WILL BE FAXING\*\*\*\*\*

PROVIDER NAME	* PROVIDER TAX ID #	PROVIDER ADDRESS, CITY, STATE & ZIP	START DATE	END DATE	NAME OF DEPENDENT	AMOUNT
<b>* Your claim cannot be paid without a Provider Tax ID Number or Provider Social Security Number</b>						<b>TOTAL EXPENSES</b>

If your employer has adopted the grace period (IRB 2005-42), expenses incurred during that period (typically 75 days after the plan year ends) are eligible for reimbursement from either the current or the previous FSA plan year. If you are seeking reimbursement for expenses incurred within that period, please mark one of the boxes below to indicate the plan year from which you would like to be reimbursed. If you do not mark one of the boxes, the previous plan year's balance will be exhausted.

Reimburse from previous plan year     Reimburse from current plan year

## REIMBURSEMENT INFORMATION<sup>2</sup>

Please pay this claim by Direct Deposit to my specified account already on file with PBS.

Please issue a check for this claim.

Please pay this claim by Direct Deposit using the new information provided below.

\*If you do not select a box above, your reimbursement will be processed in the manner we have on file.

I hereby authorize Planned Benefit Systems, Inc. to initiate credit entries for my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Planned Benefit Systems, Inc. has received written notification from me of its termination in such time and in such manner as to afford Planned Benefit Systems, Inc. a reasonable opportunity to act on it.

ACCOUNT NUMBER: \_\_\_\_\_ ROUTING NUMBER: \_\_\_\_\_

Must be 9 digits

BANK NAME: \_\_\_\_\_  CHECKING ACCOUNT     SAVINGS ACCOUNT

## EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these expenses will not be claimed again when filing IRS form 1040 and were incurred for eligible dependents. I certify that these dependent care expenses have not already been reimbursed under this plan or any other plan and will not be reimbursed under any other employer plans or coverage. I certify that these expenses have not been paid to anyone who is my child or stepchild under the age of 19 and claimed as a dependent on my income tax return. **I understand that I am responsible for acquiring and retaining receipts from my provider for services claimed under this plan. I further understand that I am responsible for reporting the Tax ID# provided above on IRS Form 2441 when I file my federal income taxes.** I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand.

**PLANNED BENEFIT SYSTEMS CANNOT PROCESS THIS CLAIM WITHOUT A SIGNATURE BELOW**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Planned Benefit Systems, Inc. • [www.cci-pbs.com](http://www.cci-pbs.com)  
P.O. Box 4594, Greenwood Village, CO 80155-4594  
Customer Service 800-800-0133  
Fax 303-221-2785

## HOW TO FILE YOUR CLAIM

COMPLETE AND SIGN YOUR CLAIM FORM AND REMIT TO PBS IN ONE OF THE FOLLOWING WAYS:

FAX: 303-221-2785

MAIL: PLANNED BENEFIT SYSTEMS, INC.  
P.O. Box 4594  
Greenwood Village, CO 80155-4594

EMAIL: [pbsclaims@cci-pbs.com](mailto:pbsclaims@cci-pbs.com)

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

## THINGS TO REMEMBER ABOUT DEPENDENT CARE REIMBURSEMENTS

- A Caregiver Tax ID Number or Social Security Number must be provided in order to have your claim processed. According to IRS guidelines, it is your responsibility to acquire and retain Provider Receipts.
- The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse.
- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your income tax return.
- An eligible dependent is someone who spends at least 8 hours a day in your home and is one of the following:
  - A child under the age of 13 for whom you can claim as an exemption for income tax purposes.
  - A dependent under the age of 13 for whom you have custody for more than half of the year if you are divorced or legally separated.
  - A dependent that is physically or mentally incapable of self-care (regardless of age).
  - Your spouse who is physically or mentally incapable of self-care.
- Extended overnight summer camps, private Kindergarten and higher-grade tuition, non-work related babysitting expenses and long term care services **ARE NOT** eligible expenses. The only expenses that are considered eligible under the Dependent Care FSA are those that are incurred while you or your spouse are working, looking for work, or attending school full time.
- Your claim will be processed within 7 to 10 business days. You will receive notification by mail, thereafter, if any portion cannot be paid for any reason.

<sup>1</sup> **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, [help@cci-pbs.com](mailto:help@cci-pbs.com), to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at [www.cci-pbs.com](http://www.cci-pbs.com). Select *Planned Benefit Systems*, then *Account Information* under the Participants section and then log in under Employee and Cardholder Login. PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.

<sup>2</sup> **Reimbursement Information:** The initial direct deposit may take up to 10 days to process. Subsequent direct deposits normally take 2 business days from date of initiation. Bank holidays/weekends may affect when the deposit is credited to your account. Please contact your bank to verify all deposits are received. There will be a \$25 fee to reissue lost/stolen checks.

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