



*Health Design Plus does not insure benefits under the Plan. Your employer is solely responsible for determination of, entitlement to, and payment of, any amounts due under the plan.

Employer:

To avoid payment delays complete all information and sign this form.

Employee Name:

Employee Identification Number:

Employee's Mailing Address

Street

Apt#

City

State

Zip Code

Dependent Care Expense

Attach itemized bills or receipts for all expenses claimed. Your receipt must include the dependent's name, the period for which services were rendered, a description of the service provided, and the Employee Identification Number or Tax Identification Number of the provider. If you are not certain the expense is eligible please refer to IRS Publication 503 or consult a tax professional.

Name of Dependent:	Begin Date:	End Date:

Dependent Care Expense Total:

Name, address, and, except for certain tax exempt organizations, the taxpayer or social security identification number of the service provider:

Name of Caregiver	Address	Social Security or Tax ID Number

Dependent Care Flexible Spending Account Certification

I certify that Dependent Care Flexible Spending Account expenses submitted have been incurred for household services or for the care of a "qualifying individual" to enable me to be gainfully employed. I understand that a qualifying individual is (1) a dependent of mine under age 13, (2) a dependent of mine who is physically or mentally incapable of caring for him/her. I also certify that my spouse, if any, was either employed, looking for work, a fulltime student, or incapable of caring for himself/herself during the period the expenses were incurred. I certify that I will not be reimbursed from any other source. I further understand that no dependent care tax credit is permitted for amounts reimbursed from this account.

Employee Signature _____ **Date** _____

How to Request Dependent Care Flexible Spending Account Reimbursement

- Please fill out the Dependent Care Flexible Spending Account Claim form **completely** to avoid delay of reimbursement. Date and sign the Dependent Care Flexible Spending Account Claim form. The claim form will be returned if it is not completed, signed, or does not have the proper substantiating documentation attached.
- Please refer to IRS Publication 503 at www.irs.gov for eligible dependent care expenses and qualified caregivers.
- You have the right to appeal any denial of a claim relating to your Dependent Care Flexible Spending Account in whole or in part. Please refer to your **Summary Plan Description** for details concerning your appeal rights and information on how to formally file an appeal. Contact Customer Service at the number on your group health card for any questions.
- You may submit claims for dependent care expenses on this account for 90 days after the plan year ends as long as the expense was incurred **before** the end of the plan year.

NOTE: If your plan designates a grace period, you may submit claims incurred for an additional 75 days after the end of the plan year. Any contributions left over at the end of the grace period will be forfeited.

Claims received by HDP will be processed using the first-in, first-out method. It is possible that claims for expenses in Plan Year 1 may be denied because Plan Year 2 claims for expenses incurred within the grace period were submitted first and processed (exhausting the available funds).

Mail Completed Form & Documentation to:

**Health Design Plus/ Flex Department
1755 Georgetown Road
Hudson, OH 44236**