Dependent Care Reimbursement Provider Statement

Medcom Benefit Solutions
Jacksonville, Florida
www.medcombenefits.com

To avoid claim delay, all sections must be completed

A. Employee Information

Social Security Number	Last Name	First Name	Middle Initial

Street Address	City	State	Zip Code

Email Address*

**See email consent on back of form.*

B. Employer Information

Employer Name: Jones County Schools

C. Dependent Care Expense Information

Qualifying Person's Name	Relationship to Employee ☐ Spouse ☐ Child ☐ Other	Date of Birth (MM/DD/YYYY)

Date(s) of Service (MM-DD-YYYY)

From - - Thru - - **Amount Paid $** _____

Qualifying Person's Name	Relationship to Employee ☐ Spouse ☐ Child ☐ Other	Date of Birth (MM/DD/YYYY)

Date(s) of Service (MM-DD-YYYY)

From - - Thru - - **Amount Paid $** _____

If you would like your Dependent Care claim set up as a recurring claim for the year, please check this box. ☐

For recurring Dependent Care claims, please include an itemized receipt that includes the total cost of your daycare expenses for the plan year. Your claim will be entered based on your annual election and paid in full as payroll deposits accumulate in your account. It will be your responsibility to advise Medcom if you have a cost change.

D. Provider Information

Caregiver Name Relative: ☐ Yes ☐ No	Social Security Number or Tax ID of Caregiver
Address of Caregiver/Provider	Telephone Number of Caregiver/Provider

E. Employee/Caregiver Certification

EMPLOYEE - I certify that all the expenses listed above for which I am seeking reimbursement from the Dependent Care Account have been incurred. I further certify that these expenses have not been reimbursed, nor shall I seek reimbursement, from any other dependent care assistance program. I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, nor will I claim a tax deduction or credit for these expenses on my state or local tax returns in violation of state or local law. I further certify that the above dependent care expenses are for the care of a Qualifying Person and do not include separate charges for food, clothing, education, entertainment, activities, late fees, or overnight care. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement. Any person who knowingly and with intent to defraud that files a statement of claim containing any materially incomplete, misleading, or false information is guilty of a crime.

Signature of Employee: **Date:**

CAREGIVER - I certify that I am a qualified caregiver as defined by the Internal Revenue Code and that the expenses for services claimed above have actually been provided. Any person who knowingly and with intent that files a statement of claim containing any materially false, incomplete, or misleading information is guilty of a crime.

Signature of Caregiver: **Date:**

Contact Us:
(800) 523-7542, option 1
medcomreceipts@medcombenefits.com
www.medcombenefits.com

Instructions for submitting your claim

Please make copies for your records as claim information cannot be returned.
Please do not highlight anything on the form, as this makes it illegible.

Section A- Employee Information

Complete all information in this section. Any changes should also be reported to your employer.

Email Consent - By providing your email address you are consenting to receive electronic communications at this email address, for any and all matters permitted by law regarding this Plan, which is sent by, or on behalf of, the Plan or your employer. By providing your email address, you will no longer receive printed copies of communication which are sent to you electronically. I certify that I have access to this email address and am able to receive electronic messages with attachments at this email address. I understand that I may request a paper copy of any correspondence provided electronically at no charge by contacting the Plan Administrator in writing. I may revoke this consent at any time by notifying the Plan Administrator in writing. If I should no longer have access to the email address last provided to the Plan Administrator, I shall immediately provide a new email address or revoke this consent.

Section B - Employer Information

List the employer/company name.

Section C - Dependent Care Expense Information

List and separate expenses by each qualifying person.

Section D - Caregiver Information

List and separate expenses for each Qualifying Person.

A qualifying person is:

1. Your qualifying child who is your dependent and who was under age 13 when the care was provided.
2. Your spouse who is physically or mentally unable to care for themselves and lives with you for more than half the year. A person who is physically or mentally incapable of self-care cannot dress, clean, or feed themselves because of physical or mental problems.
3. A person who is physically or mentally unable to care for himself or herself and lives with you for more than half of the year, and either:
   - Is your dependent, or
   - Would be your dependent except that:
     - He or she receives gross income in excess of the exemption amount, or
     - He or she files a joint return, or
     - You, or your spouse, if filing jointly, can be claimed as a dependent on someone else's return.

For more information about who is a qualifying person, refer to Publication 503 at http://www.irs.gov

Please Note: A non-custodial parent cannot participate in a dependent care FSA, even if the non-custodial parent claims the dependency exemption for the qualified person.

Qualified expenses must have been incurred to enable you (or, if you are married, you and your spouse) to work or to look for work.

You may also qualify if your spouse is a full-time student or incapable of self-care.

- In-home services for the care of a qualifying person, including baby-sitters and nannies.
- Services of a dependent care center for the care of a qualified person. A dependent care center is any facility that provides care for more than six individuals (other than residents), receives payments or grants for providing dependent care services, and meets all requirements of state and local law.
- Adult day care. Summer day camp, including a camp that specializes in a particular activity.
- When provided by the care provider, transportation expenses to and from the care location are eligible for reimbursement.

Additional Notes Regarding Requests for Reimbursements:

- Services are considered incurred when they have been rendered or received, regardless of when you paid for the services.
- The qualifying person must regularly spend at least 8 hours per day in your home.
- Unless your caregiver fee is paid on a weekly or longer basis and you are required to pay regardless of attendance, expenses for days that you do not work (i.e., part-time workers) or are not looking for work or attending school are not eligible for reimbursement.
- If you receive any reimbursements from your dependent care flexible spending account, the IRS requires that you complete Form 2441 and attach it to your federal income tax return. Form 2441 requires the following dependent care provider information: name, address, SSN/TIN, and amount to be paid. If you do not provide this information to the IRS, you may lose the tax benefits of your flexible spending account. Refer to the IRS website at **http://www.irs.gov** for forms, instructions, publications, and more information.

Section E - Employee/Caregiver Certification

Payments made to your spouse, the parent of your qualifying child, your child under age 19 (even if not your dependent) or a person whom you claim as a dependent on your tax return are not reimbursable.

You must sign and date this form to avoid claim payment delays.

Contact Us:
(800) 523-7542, option 1
medcomreceipts@medcombenefits.com
www.medcombenefits.com