PROVIDER INFORMATION

Dependent Care Flexible Spending Plan

Reset

"Provider" means your day care facility, baby sitter, or pre-school. Plan rules require that specific information must be provided to the Plan Administrator before your reimbursement for Dependent Care expenses can be approved.

Likewise, plan rules require that you attest that your expenses are incurred to make it possible for you, and or your spouse, to go to work. You must also declare that each of your applicable dependents meet two additional criteria: (1) each dependent is under age 13, and (2) for each day of care provided, your dependent child resides in your home. In special circumstances, a dependent may also be an older child, or a spouse, who resides in your home, but requires day care that makes it possible for you to go to work.

Examples of Provider expenses that are NOT eligible would be: (a) expenses incurred so that you could go out to dinner for the evening (expenses must be work related); or (b) expenses incurred for your 15 year old to attend a special 5-day summer camp (a child must be under age 13 and the child must reside with you in your home for at least a portion of each day that expenses are claimed); or (c) day care expenses incurred by your child who lives with an ex-spouse in another city (again, your child must reside with you for at least a portion of each day.) Expenses would be eligible while you have custody of your child and you incur the provider expense making it possible for you to go to work that day.

Please provide the following information:

(1) The name and date of birth of each of your children eligible for Dependent Care:

NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____

(2) The name and address of your Dependent Care Provider:

Name: _____

Street: _____

City State ZIP: _____

(3) If your Provider is related to you, the Employee, please state the relationship:_____

(4) The social security number, or Federal Tax-ID number, of your Provider: _____

Failure to provide the Plan Administrator with this Provider information will cause a delay of reimbursement, or possible denial of claims for reimbursement for Dependent Care Expenses. By my signature below, I attest that I have not violated the Plan rules, stated above. I will notify the Plan Administrator in the event my dependent child is no longer eligible for expense reimbursement under this Plan.

_____ Your Employer's Name

_____ Your Printed Name

_____ Your Social Security Number

_____ Your Signature

_____ Date

RETURN THIS FORM TO P.R.I.M.E. BENEFIT SYSTEMS, P.O. BOX 2239, CEDAR RAPIDS, IA 52406-2239.
If you have any questions, please call P.R.I.M.E. Benefit Systems at (319) 393-2005.