

NORWICH UNIVERSITY
DEPENDENT CARE FLEXIBLE SPENDING
CLAIM FORM - _____ PLAN YEAR

This claim form is to be used only to request reimbursement from your Flexible Spending Account for dependent care expenses. In all cases, the actual bill that you received or receipt of payment and/or other evidence that you have incurred the expense must be submitted, with this claim form, when requesting reimbursement.

IN ALL CASES, YOU MUST SIGN THE BOTTOM OF THIS FORM IN ORDER TO RECEIVE REIMBURSEMENT.

Employee (Please print)	Employee ID #
Address (Number, Street, City, State and Zip Code)	

Name of Dependent(s) (First, Last)	Date of Birth / /	Dependent ID #
Name of Dependent(s) (First, Last)	Date of Birth / /	Dependent ID#
Name of Dependent(s) (First, Last)	Date of Birth / /	Dependent ID#
Relationship to Employee	Name of Preschool or Day-Care Provider	

Amount of Reimbursement Requested:	\$
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I certify that the dependent care expenses being submitted for reimbursement meet the requirements as stated on the reverse of this form. Further, I understand that I have the responsibility for any tax or other legal reporting requirements with respect to reimbursed expenses. I also understand that, to the extent dependent care expenses are reimbursed under this Plan, they may not be claimed as expenses for purposes of the credit against federal income tax for dependent care expenses.

Employee Signature

Date

DEPENDENT CARE EXPENSES BEING SUBMITTED FOR REIMBURSEMENT MUST MEET THE FOLLOWING REQUIRREMENTS:

1. The dependent care expenses for which I am asking reimbursement have actually been, or will be, paid by me and/or my spouse (if applicable).
2. These dependent care expenses were incurred by me and/or my spouse (if applicable) and/or a qualifying individual during the period January 1 through December 31, or the period that I was covered under this plan, whichever is less.
3. The expenses are for the care of a qualifying individual (see #4 below) in a facility such as a day-care center, day-care home or nursery school, or for dependent care services in my home. I understand that educational expenses for a child in the first or higher grades are not eligible.
4. I understand a qualifying individual is one of the following:
 - (a) A child under age 13 for whom I claim an exemption deduction on my Federal Income Tax Return; or
 - (b) A child under age 13 for whom I have custody for a greater period of time than the child's other parent, as I am divorced, legally separated or separated under a written separation agreement; or
 - (c) My spouse who is physically or mentally not able to care for himself or herself; or
 - (d) A dependent of mine who is physically or mentally unable to care for himself/herself and for whom I can claim an exemption deduction on my Federal Income Tax return. This includes dependents for whom I could claim a tax exemption this year, but for the fact that person has gross income of at least the exemption amount under IRS Code Section 151(d).
5. The expenses are for the purpose of allowing me (and my spouse, if applicable) to be gainfully employed during the period I have responsibility for a qualifying individual. I know that payments made to a child of mine under age 19 or to a person I can claim as a dependent on my Federal Income Tax return are not reimbursable expenses.
6. If I am married, the amount of reimbursable expenses cannot exceed the lesser of my earning or my spouse's earning for our tax year. In the circumstances of my spouse being either a full-time student or physically or mentally incapable of self-care, I understand that my spouse is considered to have earnings of \$250 per month (or \$500 per month if I have at least two qualifying individuals).

FOR OFFICE USE ONLY: Date Received: / / FSA_DC_BAL: \$

Paid Previously: ____Yes ____No Date Paid: / / By: