

**NORWICH UNIVERSITY
DEPENDENT CARE FLEXIBLE SPENDING
ACCOUNT PLAN**

Claim Form - 2009 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 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

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

Name of Dependent(s)	Date of Birth
Name of Dependent(s)	Date of Birth
Name of Dependent(s)	Date of Birth
Relationship to Employee	Name of Preschool or Day-Care Provider

Amount of Reimbursement Requested: \$ _____

*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 REQUIREMENTS:

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 of January 1, 2009 through December 31, 2009 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 kindergarten or higher grades are not eligible.
4. I understand a qualifying individual is one of the following:
 - (a) a dependent under age 13 whom you are entitled to claim as a dependent (or a child or other dependent under age 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce) on your federal income tax return, or
 - (b) a spouse or other tax dependent (or a child you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce) who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the taxable year.
5. The expenses are for the purposes 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 earnings or my spouse's earnings 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: _____ Reason Declined: _____
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