



FLEXIBLE SPENDING ACCOUNT DEPENDENT CARE EXPENSE CLAIM FORM

PLAN & EMPLOYEE INFORMATION

Check here if you have an address or name change

FIRST NAME: _____ LAST NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAYTIME PHONE: _____ E-MAIL: _____ DATE OF BIRTH: ____/____/____

EMPLOYER NAME: _____ PLAN YEAR: _____

DEPENDENT CARE EXPENSES

PROVIDER NAME	* PROVIDER TAX ID #	PROVIDER ADDRESS, CITY, STATE & ZIP	SERVICE PERIOD	NAME OF DEPENDENT	AMOUNT
* Your claim cannot be paid without a Provider Tax ID Number or Provider Social Security Number					TOTAL EXPENSES

If your employer has adopted the grace period (IRB 2005-42), expenses incurred during that period (typically 75 days after the plan year ends) are eligible for reimbursement from either the current or the previous FSA plan year. If you are seeking reimbursement for expenses incurred within that period, please mark one of the boxes below to indicate the plan year from which you would like to be reimbursed. If you do not mark one of the boxes, the previous plan year's balance will be exhausted.

Reimburse from previous plan year Reimburse from current plan year

REIMBURSEMENT INFORMATION

Please pay this claim by Direct Deposit to my specified account already on file with PBS.

Please issue a check for this claim.

Please pay this claim by Direct Deposit using the new information provided below.

I hereby authorize Planned Benefit Systems, Inc. to initiate credit entries for my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Planned Benefit Systems, Inc. has received written notification from me of its termination in such time and in such manner as to afford Planned Benefit Systems, Inc. a reasonable opportunity to act on it.

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

BANK NAME: _____ CHECKING ACCOUNT SAVINGS ACCOUNT

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these expenses will not be claimed again when filing IRS form 1040 and were incurred for eligible dependents. I certify that these dependent care expenses have not already been reimbursed under this plan or any other plan and will not be reimbursed under any other employer plans or coverage. I certify that these expenses have not been paid to anyone who is my child or stepchild under the age of 19 and claimed as a dependent on my income tax return. **I understand that I am responsible for acquiring and retaining receipts from my provider for services claimed under this plan. I further understand that I am responsible for reporting the Tax ID# provided above on IRS Form 2441 when I file my federal income taxes.** I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand.

PLANNED BENEFIT SYSTEMS CANNOT PROCESS THIS CLAIM WITHOUT A SIGNATURE BELOW

SIGNATURE: _____ DATE: _____

Planned Benefit Systems, Inc. www.cci-pbs.com
P.O. Box 4594, Greenwood Village, CO 80155-4594
Customer Service 800-800-0133
Fax 303-221-2785

HOW TO FILE YOUR CLAIM

COMPLETE AND SIGN YOUR CLAIM FORM AND REMIT TO PBS ONE OF THE FOLLOWING WAYS:

FAX: 303-221-2785

MAIL: PLANNED BENEFIT SYSTEMS, INC.
P.O. Box 4594
Greenwood Village, CO 80155-4594

EMAIL: pbsclaims@cci-pbs.com

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

THINGS TO REMEMBER ABOUT DEPENDENT CARE REIMBURSEMENTS

- We do not require Dependent Care receipts with a Provider Tax ID Number or Provider Social Security Number. According to IRS guidelines, it is your responsibility to acquire and retain Provider Receipts.
- The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse.
- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your income tax return.
- An eligible dependent is someone who spends at least 8 hours a day in your home and is one of the following:
 - A child under the age of 13 for whom you can claim as an exemption for income tax purposes.
 - A dependent under the age of 13 for whom you have custody for more than half of the year if you are divorced or legally separated.
 - A dependent that is physically or mentally incapable of self-care (regardless of age).
 - Your spouse who is physically or mentally incapable of self-care.
- Extended overnight summer camps, private Kindergarten and higher-grade tuition, non-work related babysitting expenses and long term care services ARE NOT eligible expenses. The only expenses that are considered eligible under the Dependent Care FSA are those that are incurred while you or your spouse are working, looking for work, or attending school full time.
- You will receive notification within 7 to 10 business days after receipt of your claim form if your reimbursement cannot be processed for any reason.

¹ **E-Mail:** By providing your e-mail address you agree to receive FSA correspondence via e-mail. E-mail regarding your FSA plan(s) will be sent from help@cci-pbs.com ; please add this e-mail address to your e-mail address book to ensure receipt of all correspondence. You can change/delete your e-mail address by logging on to www.mbicard.com or by contacting the PBS, Inc. Customer Service Department. PBS, Inc. reserves the right to utilize an e-mail address that may be provided to us by your employer. PBS, Inc. will not share e-mail information with ANY outside source.

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