NEW YORK STATE FLEX SPENDING ACCOUNT

A STATE EMPLOYEE BENEFIT THAT PUTS MONEY IN YOUR POCKET

DEPENDENT CARE ADVANTAGE ACCOUNT REIMBURSEMENT REQUEST FORM

PLEASE READ THE INSTRUCTIONS BELOW BEFORE COMPLETING THIS FORM.

A

NAME	NYS EMPLID		
ADDRESS	CITY	STATE	ZIP

B

LIST THE NAMES AND ADDRESSES OF THE PROVIDER(S)[1] Or SERVICE FOR WHICH YOU ARE APPLYING FOR REIMBURSEMENT	PROVIDER SS# or FEDERAL TAX ID NUMBER	DATE(S) INCURRED[2] MONTH/DAY/YEAR	REIMBURSEMENT AMOUNT
1. NAME ADDRESS			
NAME & RELATIONSHIP OF PERSON RECEIVING DAY CARE:			
I HAVE RECEIVED PAYMENT FOR CARE PROVIDED. SIGNED:			DATE:
2. NAME ADDRESS			
NAME & RELATIONSHIP OF PERSON RECEIVING DAY CARE:			
I HAVE RECEIVED PAYMENT FOR CARE PROVIDED. SIGNED:			DATE:
3. NAME ADDRESS			
NAME & RELATIONSHIP OF PERSON RECEIVING DAY CARE:			
I HAVE RECEIVED PAYMENT FOR CARE PROVIDED. SIGNED:			DATE:

[1] Provider means day care center, special school, or individual providing day care service.
[2] If the service was provided for more than one day, show the beginning date and the ending date of the service.

DATE INCURRED IS THE DATE SERVICE IS PROVIDED, NOT PAID.

(USE ADDITIONAL PAPER IF MORE SPACE IS NEEDED)

C

THE ABOVE IS A TRUE AND ACCURATE STATEMENT OF UNREIMBURSED DEPENDENT CARE EXPENSES INCURRED BY ME OR MY ELIGIBLE DEPENDENTS ON THE DATE(S) INDICATED. I UNDERSTAND THAT I AM RESPONSIBLE FOR MISREPRESENTATIONS REGARDING REQUESTS FOR REIMBURSEMENT. THE SIGNATURE OF THE CARE PROVIDER(S) REPRESENTS RECEIPT FOR ALL CLAIMED EXPENSES. I UNDERSTAND THAT EXPENSES REIMBURSED HEREIN CANNOT BE CLAIMED ON MY INCOME TAX RETURN. ALL DEPENDENT CARE EXPENSES WERE INCURRED TO ENABLE ME AND MY SPOUSE, IF APPLICABLE, TO WORK OR LOOK FOR WORK (OR, MY SPOUSE IS A FULL-TIME STUDENT OR INCAPABLE OF SELF CARE).

SIGNATURE _____ DATE _____

IMPORTANT INSTRUCTIONS AND INFORMATION!

Please Print or Type

1. This Reimbursement Request form must be signed by you and your care provider(s), or you may attach separate receipts from your service providers that list the name, address and tax ID number (or SS#) of the provider. Requests will not be processed without this information.
2. Reimbursement can only be made for those expenses resulting from services that occur during the Plan Year.
3. Any unused year-end balance in your DCAAccount may not be carried over to the next plan year. The funds will be forfeited and returned to NYS, as your employer.
4. The deadline to incur expenses is the last day of the month of the plan year. However, NYS allows a 90-day runout period after the end of the Plan Year, during which time you may submit reimbursement requests for services incurred during the previous Plan Year. Reimbursement Requests postmarked later than March 31st will not be processed.
5. If dates of service for which you are seeking reimbursement begin in one Plan Year and end in the next Plan Year, a Reimbursement Request form for each year is required.
6. Be sure to sign and date **SECTION C**.
7. Call 1-800-358-7202 (option 1) for Customer Service, Fringe Benefits Management Company, Plan Administrator for the Dependent Care Advantage Account Program.
8. Mail or fax to:
   FRINGE BENEFITS MANAGEMENT COMPANY, A Division of WageWorks
   P.O. BOX 1820, TALLAHASSEE, FL 32302
   or
   TRIM YOUR DEPENDENT CARE EXPENSES—FAX FREE!
   1-800-743-3271

FBMC USE ONLY: DATE RECEIVED: _____ AUTHORIZATION #_____ INITIAL _____

INSTRUCTIONS FOR REIMBURSEMENT

GENERAL INSTRUCTIONS

- Services must have been incurred to receive reimbursement. You may not request reimbursement until you have received the service, regardless of when you pay for it.

- Reimbursement can only be made for expenses for services that have been provided within the plan year.

- According to the IRS regulations, any unused year-end balance in your spending account may not be carried over to the next plan year. Monies must be forfeited to New York State and will be used to defray administrative costs of the NYS Flex Spending Account program.

- If dates of service for which you are seeking reimbursement begin in one plan year and end in the next plan year, *a separate Reimbursement Request form is required for each year.*

- New York State allows a 90-day runout period after the end of the plan year. During this time you may submit Reimbursement Requests for services incurred during the plan year.

- **Be sure to sign and date SECTION C.**

ADDITIONAL DCAAccount INSTRUCTIONS

- According to the IRS regulations, dependent care reimbursement requests cannot be processed without receipts from the provider showing the name, address, and tax ID number (or social security number) of the provider. Beginning and ending dates of service are required on the dependent care receipt. If the receipt is from an individual care provider you **MUST** have the provider sign the above-mentioned receipt, **or** you may use the Reimbursement Request form as a receipt if **SECTION B** is co-signed by your care provider.

- Fringe Benefits Management Company will be unable to authorize payment until **after** the last date of service for which you are requesting reimbursement.

- Copies of canceled checks are not sufficient receipts for IRS purposes.

- A qualified dependent is your dependent under age 13, your dependent who is physically or mentally incapable of self-care, or your spouse who is physically or mentally unable to care for himself or herself. According to the IRS, physical or mental incapacity is not being able to dress, clean, or feed oneself.

- Payments for dependent care cannot be made to someone you or your spouse claim as a dependent. If the person you make payments to is your child, he or she must be age 19 or older by the end of the year.

- Overnight camp expenses do not qualify for dependent day care reimbursement.

- Tuition for Kindergarten or higher is not eligible for reimbursement. However, if tuition paid for Kindergarten or higher includes eligible expenses for before and after-school care, you may be reimbursed for that portion of the tuition providing the before and after-school care.

Fringe Benefits Management Company, A Division of WageWorks
P.O. Box 1820
Tallahassee, FL 32302-1800

Customer Service
1-800-358-7202 (option 1)