Dependent Care Assistance Plan

Claim Form

EMPLOYER INFORMATION

Company Name

EMPLOYEE INFORMATION

Employee Last Name	First Name	Social Security Number	
Street Address	**City**	**State**	**Zip**
Daytime Phone Number	**Email**		

DEPENDENT CARE ASSISTANCE PLAN ("DCAP") PROVIDER

Service	**Provider Information**		
Beginning Date - Ending Date	**Facility Name**	**Address**	**Tax ID**
Signature of Provider (or attach a cancelled check or a receipt from the provider if one exists.)			

DEPENDENT CARE ASSISTANCE PLAN ("DCAP") EXPENSES

Person Receiving Service			
Name	**Relationship to Employee**	**Birthdate**	**Amount of Expense**

ELIGIBLE EXPENSES:

Eligible expenses under a Dependent Care Assistance Plan are defined as those that enable the participant and the participant's spouse to work or to look for work. They include the following:

- Child care centers that care for six or more children and that meet the IRS's definition of a qualified day care center;
- Caregivers for a disabled spouse or dependent who lives with the participant
- Babysitters;
- Nursery schools;
- Household expenses, provided that a portion of such expenses are incurred to ensure a qualifying dependent's well-being and protection.

INELIGIBLE EXPENSES:

- Babysitting for social events;
- Educational expenses; and
- Charges for overnight camp.

The day care provider's name, address and TIN must be included on your annual income tax return by completing Form 2441 or Schedule 2 of Form 1040A.

TERMS AND CONDITIONS

1. I request payment from my reimbursement account for the expenses itemized above.
2. I certify that I have not requested reimbursement under this plan or from any other source for these expenses.
3. I also certify that the total dependent care expenses which I am submitting this plan year do not exceed the lesser of my or my spouses earned income for the year.
4. I further certify that I have met all of the requirements for eligible dependent care expenses as described on this form and the DCAP Summary Plan Description.
5. I understand that reimbursement expenses cannot be claimed on my personal income tax return.
6. I represent that the dependent claimed is either (i) a child under age 13 or (ii) a dependent that is disabled.

I have read and agree to the terms and conditions set forth on this Agreement.

Employee Signature	Date

Send completed form and documentation to TotalBen.

FAX: (718) 535-7071

Mail: TotalBen LLC
P.O. Box 100496
Brooklyn, NY 11210