

Dependent Care Spending Account Reimbursement Form

Disbursements will be made on alternating Wednesdays. This form must be completely filled out and received by Zenith Administrators no later than the Friday prior to the disbursement in order to be included.

SECTION ONE : PARTICIPANT INFORMATION

Last Name:	First Name:	M.I.	Home Phone Number:
Mailing Address:			Work Phone Number:
City:	State:	Zip Code:	Participant's Social Security Number: ____-____-____
Is this a new address for you? <input type="checkbox"/> YES <input type="checkbox"/> NO			

SECTION TWO: DEPENDENT CARE INFORMATION

Care Provider's Name:	Care Provider's Tax ID Number / Social Security Number:
Care Provider's Mailing Address:	
City:	State: Zip Code:

Dependent's Name	Date of Birth	Relationship	Dates Care Provided	Charges

SECTION THREE: PROVIDER CERTIFICATION

The care provider must sign here certifying that the information in Section Two is correct, or you must attach an invoice that has been signed by the care provider and that contains the same detailed information described in Section Two.

I certify that the information in Section Two, Dependent Care Information, is true and correct to the best of my knowledge. I understand that certifying fraudulent information in support of obtaining benefits is a crime punishable by law.

_____ _____
 Care Provider's Signature Date

SECTION FOUR: IRS GUIDELINES

1. Care was for dependent child under age 13 or spouse or other dependent individual.
2. Care was employment related.
3. Care was not provided by other dependents or my children under age 19.
4. Charges are not for overnight camp.
5. No other assistance, reimbursement, or tax credit has been or will be received for the expenses.
6. If provider was a day care center, it complies with state and local laws.
7. The service listed above has been provided and the expense has been incurred.

SECTION FIVE: PARTICIPANT CERTIFICATION AND SIGNATURE

I certify that the information on this form is true and correct to the best of my knowledge and that this reimbursement request meets the IRS guidelines listed in Section Four. I further understand that certifying fraudulent information for the purpose of obtaining benefits is a crime punishable by law.

_____ _____
 Participant's Signature Date

For Trust Administrative Office Use Only

Date Received: _____ Initial: _____ Date Processed: _____ Initial: _____

<ul style="list-style-type: none"> • Complete all sections of this form. • For reimbursement from this account, you must include the following. <ul style="list-style-type: none"> ✓ Provider’s tax identification number or Social Security number. (see Section Two) ✓ Provider’s signature of certification. (see Section Three) ✓ Cancelled checks alone cannot be accepted as documentation of expenses. ✓ Please retain a copy of this form and all documentation for your records. Originals will not be returned. 	<p>Mail completed form and original documentation to:</p> <p>Zenith Administrators, Inc. FSA Department P.O. Box 91082 Seattle, WA 98111-9182</p>
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REIMBURSABLE DEPENDENT CARE EXPENSES

- Household services if the care of a qualifying dependent is included, and the person providing the services is not your dependent child under age 19 or any other person you or your spouse claim as a dependent for tax purposes.
 - Dependent care centers if the center provides care for more than six individuals and complies with all state and local laws and regulations.
 - Services by individuals, including relatives, as long as they are not your dependents.
- NOTE: A complete list of eligible dependent care expenses is in IRS Publication #503.
- Expenses reimbursed with tax-free dollars from your account can be for the care of both dependent children and dependent adults, such as parents or grandparents. Expenses must be for the care of children age 12 and under or, for dependents older than age 12, they must meet all of these requirements:
- Be physically or mentally unable to care for themselves.
 - Spend at least eight hours a day in your home.
 - Depend on you for support.
 - Be listed as a dependent on your federal income tax return.

ADDITIONAL INFORMATION

CONTACT INFORMATION

- You may check your FSA account balance and claims history at any time on our web site at www.zenithfsa.com or by using our integrated voice response Flex Hotline at 1-866-206-2345. If you need personalized assistance, contact our FSA Department at 1-800-426-5980, extension 580.