

Dependent Care Reimbursement Request Form Instructions

Eligible Services and Documentation Requirements:

Dependent Care expenses are those services that are rendered for the care of a qualifying individual to enable you and your spouse (if applicable) to be gainfully employed. **A qualifying individual is:**

- Your dependent(s) under 13 years of age if you are entitled to a personal exemption for the dependent, or
- A dependent or spouse who is physically or mentally incapable of caring for themselves.
- A dependent that regularly spends at least eight (8) hours each day in your home.

Examples of **covered** dependent care expenses include, but are not limited to:

- Care outside of your home (such as a child care center or babysitter) for qualified individuals (see above).
- Care inside your home (such as a nanny) for qualified individuals (see above).

Examples of **non-covered** dependent care expenses include, but are not limited to:

- Educational programs including grades kindergarten and above
- Overnight camp
- Day camp, if not primarily for the purpose of custodial care

Care may be provided by a relative as long as the relative is not

- one for whom you can take a personal exemption as a dependent
- your spouse
- a child under the age of 19.

Supporting documentation must accompany this request form. Supporting documentation includes bills, receipts or other evidence, which provides dates of service, name of provider and dollar amounts. **If you are unable to provide a third party statement please have your provider sign the "Affidavit of Dependent Care Services Rendered" section on the claim form.**

Balance forward statements, bank statements and checks (copies of initial and/pr cancelled checks) are not acceptable.

We reserve the right to request additional documentation as needed.

Please ensure that all receipts are legible. Once received, claims are scanned (similar to photocopying). Documents that are too light, too dark, or with fonts too small will cause delay. We suggest sending us a photocopy of receipts and retaining the originals for your records. Please do not highlight documents as this will not show on the scanned image.

Payments:

All reimbursements are paid to you and cannot be assigned to any other person. Checks and Explanations of Payment will be mailed to the home address on file.

You can submit reimbursement requests at any time; however, you will only be reimbursed up to the amount that is in your dependent care account at the time your request is received. The balance of the claim will be paid automatically as money is deposited into your account.

Request Submission:

Complete the Dependent Care Spending Account Reimbursement form and submit it along with your supporting documentation to:

Personal Choice Account
PO Box 3199
Portland, OR 97208-3199

Retain a copy of the reimbursement request form and copies of supporting documents for your records as those submitted will not be returned.

Questions:

Email pca@regence.com or call us at (503) 412-5688 or (800) 334-4340

**Dependent Care Reimbursement
Request Form**

PLEASE SEE INSTRUCTIONS AND INFORMATION IN PREPARING AND SUBMITTING THIS FORM

Please complete ALL information in this section. Incomplete forms may result in delay or denial.

Employer / Group Name	Preferred Method of Communication (provide email or phone number)
Participant Name (Last, First, MI)	Social Security Number or Alternate Identification Number

Please list the total reimbursement requested for all Dependent Care expenses in the space provided below. Use one entry for each month in which services were performed. Attach a third party statement to document the dependents name, provider name, dates care was provided, and the charge amount. If a third party statement is not available please have the provider of care sign the "Affidavit of Dependent Care Services Rendered" statement below. Incomplete forms or missing documentation may result in delay or denial.

Dependent Name _____	Dates _____ Through _____	Fee \$ _____
Dependent Name _____	Dates _____ Through _____	Fee \$ _____
Dependent Name _____	Dates _____ Through _____	Fee \$ _____

TOTAL REIMBURSEMENT REQUESTED \$ _____

Affidavit of Dependent Care Services Rendered

I have provided care for (dependent) _____ for the period beginning on _____ and ending _____. Services were provided to (participant) _____ for the fee of \$ _____.

Signature of Care Giver _____ Date _____

After reading the submission instructions and completing this form, please read and sign the statement below. Unsigned claims will be rejected.

The Internal Revenue Code permits Personal Choice Account (PCA) reimbursements only for tax-deductible expenses. Neither PCA nor the Plan Sponsor are liable to the participant or any other entity for taxes, interest, penalties or other consequences which may be assessed by any taxing authority for disallowed expenses. Furthermore, neither entity will be responsible for banking charges that may be incurred.

I request reimbursement for the attached expenses under the Dependent Care Reimbursement Account Plan. I certify that I or my eligible tax dependents have incurred these services and that they are reimbursable under the terms of my employer's Dependent Care Reimbursement Program. I understand that I am solely responsible for the validity of claims submitted to my Flexible Spending Account. These services have not been reimbursed prior to this submission and are not reimbursable by any other source.

PLAN PARTICIPANTS SIGNATURE

DATE

If you have any questions regarding your Personal Choice Account or how to complete this form, please call 503-412-5688 or toll free 1-800-334-4340. You may also visit our website at www.personalchoiceaccount.com or email us at pca@regence.com.

Submit signed reimbursement form to:

Personal Choice Account
PO Box 3199
Portland, OR 97208-3199
Or fax to: (503) 225-5353 or 1(800) 979-8987