



DEPENDENT CARE CLAIM FORM

Social Security No.: _____

Participant's Name: _____
Last First Middle

Campus Name: _____

The undersigned participant in the Plan requests reimbursement (**attach itemized bills, receipts and invoices for all expenses claimed**) in the amounts shown below:

DEPENDENT CARE EXPENSE	
Name of Dependent(s): _____	
Period Covered:	From _____ through _____
Service Provider Information:	
Provider Taxpayer ID # (Social Security Number): _____	
Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Total amount of dependent care expenses claimed: \$ _____	

CHILD CARE PROVIDER STATEMENT <i>(in lieu of receipt or bill)</i>	
I have received \$ _____ for the care of the individuals listed above on the dates specified.	
_____	_____
<i>Child Care Provider Signature</i>	<i>Date</i>

NOTE: The total amount claimed under the Plan for the Plan year must not exceed the lesser of your wages or salary for the Plan year or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent, and \$500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY: The undersigned participant in the Plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the **Choices: The Montana University System's Flexible Benefit Program** with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

Employee's Signature _____
Date

Adequately documented claims will be processed within three working days of receipt.

Claims may be sent to:	FlexConnect, P.O. Box 2019, Helena, MT 59624
Contact us at:	Phone: (406) 442-3539 or (866) 640-3539 - Fax: (406) 495-3669
	Visit our Website at www.insurancecoordinators.com