CONSOCIATE HEALTH

Annual Dependent Care Claim Form

Employee's Name: _____ Date of Birth: _____

Phone: _____ Email: _____

This claim form should only be used when you and your provider are entered into an annual contract for daycare services. If you should have an annual contract with your daycare provider, dependent care claims may be filed just once per year by completing this claim form and either:

1. Attaching a copy of the annual contract or
2. Obtaining the provider's signature on the bottom of this claim form

Reimbursements will be made as contributions are deposited into your dependent care flexible spending account from your payroll deductions. Dependent care claims filed under the annual contract section are only honored for the current calendar year. You must resubmit a new claim form at the beginning of each calendar year.

Name of Dependent (s)	Period Covered		Name, Address, and Taxpayer Identificatio Number of Provider of Service	Calendar Year Contracted Amount
	From	To		
			Total Dependent Care Expense Claim**	

Read Carefully: The undersigned participant in the Plan certifies that all service for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the dependent care expenses have not been reimbursed or are not reimbursable under any other dependent care plan coverage. 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 payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which related to such expense.

Employee's Signature: _____ Date: _____

Provider Signature***: _____ Date: _____

*If you file a dependent care expense claim form based on an annual contract for reimbursement as contributions accumulate, it is your responsibility to notify Consociate-Dansig of any and all changes to dependent care arrangements (including but not limited to fees, contracts or providers). Failure to do so may result in tax consequences, which will be your responsibility.

**NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income 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, or $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 of 19.

***The provider's signature certifies that he/she has provided adult or child care services to the above individuals in accordance with the amounts and dates that are requested.

****NOTE: Your signature certifies that you understand that no dependent care tax credit is permitted for amounts for which reimbursement in made.

Completed forms and documents should be submitted:

MAIL TO: 2828 North Monroe Street | P.O. Box 1068 | Decatur, Illinois 62525
FAX TO: 866.432.9372 or 217.233.2281 **E-MAIL TO:** flex@consociate.com