Administration Provided By:
Diversified Administration Corporation
PO Box 299, Marlborough, CT 06447
860-295-0238, toll free 888-322-2524

Section 125
DEPENDENT CARE (DCAP)
Flexible Spending Reimbursement Request Form
Rules and Instructions for completing Dependent Care Reimbursement Form:

- Please read carefully and date and sign this Form below. The Provider of Service(s) must also sign if this form is to be used as certification (substantiation) of services rendered. If the Provider does not sign this Form, you will need to attach written confirmation from the Provider that services were actually provided (incurred) prior to this Request for Dependent Care Reimbursement.
- An eligible dependent is a child under the age of 13, or can be any age, if not capable of self-care (physically or mentally handicapped).
- Qualified expenses must be employment related, and would normally be deducted on your federal income tax return as fees for day care to an eligible dependent while you are at work (and, if your spouse either works, is disabled, or is a full-time student). In addition; expenses do not qualify for reimbursement if they exceed your earned income or the earned income of your spouse, whichever is the lower income. Reimbursement cannot exceed $5,000.00 per year for single individuals filing head of household or married couples filing tax returns jointly ($2,500.00 if married filing separately) or the earned income of you and your spouse, whichever is less.
- You must provide the taxpayer identification number (ID #) of the provider. For individuals this will be their social security number (SSN); for corporations this will be their Employer Identification Number (EIN); for tax-exempt organizations write in "tax exempt". A Dependent Care Center must comply with all state and local laws.
- I am responsible for any occurrence of inappropriate use or disclosure of my information due to my selected method of transmitting this request (e.g. fax, e-mail or any other method).
- I understand that expenses cannot be reimbursed prior to the service date.
- The Dependent Care expenses below qualify for federal childcare credit, and I will not be eligible to claim the tax credit for this submission.
- I authorize the Plan and its service provider (DAC), their employees, and subcontractors to use and/or disclose the information provided below as they deem necessary, to manage the Plan (including but not limited to disclosures to my employer for Plan administrative purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect fraud or misrepresentation.

Please retain your original documentation/substantiation for Tax purposes.
Submit your request to: **Diversified Administration Corporation, PO Box 299, Marlborough, CT 06447; or Fax to: 860-295-6579, or 860-295-1296.**
For inquiries regarding a processed reimbursement request, contact our Flex Administrator at: 860-295-0238 or toll free at 888-322-2524; or by E-mail: eebenereim@diversifiedgb.com

Employer Information

Group Name: Research Foundation for Mental Hygiene, Inc. Group Number: DAC274G

Employee Information

Last Name: _____ First Name: _____ ID Number: _____

Address: _____ City: _____ ST: _____ Zip: _____ Ph. No._____

Reimbursement Requests for less than $10.00 will be applied to future reimbursement requests or paid at the end of the Plan Year

Provider's Name/Taxpayer ID #	Dependent Name(s)	Age	Date(s) of Service From	To	Reimbursement Request
					$
					$
					$
					$
					$
			Total Reimbursement Requested		$

Proof of service(s) attached: Yes ☐ or No ☐ (If "No", please have Provider certify services by signing below)

Provider's Signature: _____Tx ID#_____ Date: _____

Participant's Signature: _____ Date: _____

***IMPORTANT:** **Reimbursement Requests cannot be processed without participant's signature**

Rev. 11/2013