

Dependent Daycare Reimbursement Request and/or Provider Acknowledgement Form

Complete this form to meet the requirements for documenting your day care expenses. This form, once completed, may act as your receipt for expenses incurred.

INSTRUCTIONS

Complete all sections of this form. Remember to sign and date the bottom of this form.

1. **Ask** your provider to complete Section C of this form if a daycare receipt is not available.
2. **If you are unable to attach your form or document to an online or mobile app claim or alert**, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:
 - Email to flex@goigoe.com
 - Fax to 800-456-9083
 - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
3. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You ***(All information is REQUIRED. Please print clearly)**

Employer Name

Participant Name

Number of pages

Employee Number (If Applicable)

Home Address ☐ Please check if this is a change in address

City

State

Zip

E-mail Address

Phone Number

Section B: Dependent Care/Day Care Expenses Incurred

Service Date (mm/dd/yy)	DEPENDENT INFORMATION NAME, AGE, RELATIONSHIP	DESCRIPTION OF EXPENSE	NAME OF PROVIDER	PROVIDER'S TAX ID OR SSN	NET AMOUNT
-					\$
-					\$
-					\$
Total Dependent Care					\$

Section C: Provider Acknowledgement (To be completed by the daycare provider if a separate receipt is not available)

I hereby acknowledge that the above listed services were provided in compliance with any applicable federal, state and local regulations governing dependent day care centers. I further acknowledge that the dates covered, dependent information, description of the expense, name of the provider, and provider's Tax ID or SSN as listed above are correct.

Provider's Signature: _____

Date: _____

Section D: Authorization ***REQUIRED (PLEASE SIGN AND DATE)**

I certify that I am a participant in the plan from which I am requesting reimbursement and that all expenses listed with this claim were incurred during my active participation in said plan. I certify that these expenses have not been and will not be reimbursed under any other benefit plan or charged to my employer's Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information herein. I further acknowledge that each expense listed above must be a proper expense under the plan. If not, I understand that I may be liable for the payment of all related taxes including federal, state or city Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE. Having agreed to all of the proceeding statements, I authorize the account associated with the plan selected to be reduced by the amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

I confirm that I was enrolled in the Dependent Care Assistance Program on or before January 31, 2020

I believe I have access to spend funds contributed under that election as a result of a fund carryover or grace period extension event

I have a dependent that turned 13 on or before the end of 2020 or will turn 13 in the next applicable plan year. Please provide dependent name and birth date in Section B of this form.

Employee Signature _____

Date: _____

