

DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYER NAME

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EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	HOME PHONE	EMAIL ADDRESS

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered		Name, Address & Taxpayer ID No. of Provider of Service	Amount Incurred
	From	To		
PROVIDERS SIGNATURE:				
➤ Attach a receipt(s) from your daycare provider, or include the daycare provider's signature.			TOTAL DEPENDENT CARE EXPENSE CLAIM*	\$

***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/ herself, then he/she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 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.

EMPLOYEE SIGNATURE

SIGNATURE	DATE
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Mail or Fax claims to:
 Cornerstone Administrative Services, LLC - Attention: Flex Claims Department
 1350 DIVISION ROAD, SUITE 301 WEST WARWICK, RI 02893 TOLL FREE PHONE: (800) 720-4460 TOLL FREE FAX: (866) 878-2800
 (You may copy this form if additional forms are needed)