HealthPartners®

Dependent Care Expense Reimbursement Form

Employee Information — Please print clearly or complete online

Last Name | First Name | Middle Initial

Social Security Number

Employer Name | Employee ID # (if applicable)

Email Address (if you would like an email confirming this claim has been received)

For address changes, please contact your HR department.

Dependent Care Flexible Spending Account (Please print)

Date(s) service was incurred From	Through	Full name of dependent receiving service	Relationship to employee	Age(s)	Amount requested for reimbursement
					$
					$
					$
					$
				Total Reimbursement Requested	**$**

Provider Information

If supporting documentation isn't submitted, then this section will need to be completed by the Provider of dependent care services each time a form is submitted.

Provider Name | Tax I.D. # or Social Security #

Provider Signature | Date

Employee Certification

I hereby certify that the above information is correct; I have not received reimbursement previously for these expenses from any other plan; the total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000. I have read the printed materials I have received describing this plan; I will retain a copy of this form and all original receipts for my records; and I am responsible for compliance with all applicable administrative processes; tax regulations and documentation. I understand that it is my responsibility to return any duplicate reimbursement received from any other sources to my account; I am responsible for any and all bank, savings or checking account charges that I incur; and that expenses reimbursed through this account cannot be used as a deduction on my personal income tax return. I understand that if I have received an overpayment HPAI reserves the right to offset future reimbursements equal to the overpayment until the overpayment has been recouped.

Employee Signature | Date

To send online, log on to your myHealthPartners account at **healthpartners.com** and go to the Welcome tab to get started.

Fax to: 952-883-5026 or 877-624-2287

Mail to: HealthPartners Service Center, CDHP - Mail Route 21104T, P.O. Box 297, Minneapolis, MN 55440-0297

Questions: Metro Area: 952-883-7000 Outside metro: 866-443-9352
TTY line: 952-883-5127 **www.healthpartners.com**

Please retain a copy of this form and all attachments for your records.

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DEPENDENT CARE EXPENSE REIMBURSEMENT INSTRUCTIONS

What's a dependent care expense?
It's an expense for eligible child daycare and elder care. For example, it can be used to pay for:

- In-home child care.
- Licensed daycare and preschool facilities.
- Before or after school programs.
- Elder care.

It doesn't cover out-of-pocket health care costs for your children.

By signing and sending this Dependent Care Reimbursement Form, you're saying that your eligible dependent care expense is for a:

- Dependent who is either under the age of 13 or meets the "Qualifying Person Test". The test is described in IRS Publication 503. Go to **irs.gov** to view IRS Publication 503.
- Dependent who is physically or mentally unable to care for oneself. And they live with you more than half the year annually.
- Dependent care service that has already happened.

These types of expenses can't be reimbursed:

- Dependent care provided by you, your spouse, or someone you or your spouse claim as a tax dependent.
- Educational expense for a child in kindergarten and up.
- Education tuition expense.
- Expenses such as activity fees. For example: field trips, swim lessons, art classes, books, supplies, transportation and meals.

What kinds of documentation can I send?
You'll need to send one of the following:

1. A completed Provider Information section on the reimbursement form, or
2. An itemized statement or receipt with the:
   - » Provider's name and Tax ID number.
   - » Name of the dependent who received the service and their relationship to you.
   - » Date of service.
   - » The dollar amount for the service.

These items can't be used as your supporting documentation:

- Credit card receipts
- Cancelled checks
- Billing statement showing a previous or forward balance or showing received on account

Before you send your form—check for these common mistakes:

- Did you sign and date the form?
- Did you include your documentation? For more than one expense listed on a receipt be sure you circle each one. Don't highlight the expense items.
- Did you fill out the reimbursement form completely?
- Does the documentation match the amount you're asking for?
- Did you keep a copy of your reimbursement form?
- Did you send a copy of your receipts and not the originals? You'll want to keep the original receipts for your records.

Need more help?
If you need help with a dependent care expense, call HealthPartners Member Services at **952-883-7000** or **866-443-9352.**