IBM Reimbursement Request Form
Dependent Care Spending Account

INSTRUCTIONS

- Fill in the necessary information below for the dependent care expenses you incur for your eligible dependents.
- For each item, you must include a copy of a receipt from your provider. Alternately, your provider may sign this form to serve as a receipt. Each receipt must show the **provider's name, complete address, tax ID number, dates of service, and charges incurred. Canceled checks are not considered eligible receipts per IRS 125 Regulations.** Please retain your original receipts and claims filed for your records.
- **The deadline for filing claims is April 30 (postmarked by this date)** of the calendar year following the one in which expenses are incurred.
- All information submitted with this form will be protected and maintained as required by law.

If you have any questions about your account status, virtually 24 hours a day, 7 days a week, please contact us at www.acclarisonline.com or call the Acclaris Reimbursement Center toll-free at 1-888-880-2775, Monday through Friday (excluding New York Stock Exchange holidays) between 8:00 A.M. and 8:00 P.M. Eastern Standard Time to speak with a Customer Service Representative.

Please fax or mail your completed reimbursement request to:

Fax Number: 1-813-830-7900

Acclaris Reimbursement Center
PO Box 20571
Tampa, FL 33622-0571

DEPENDENT CARE REIMBURSEMENT REQUEST

Covered Period		Person Who Received the Care	Age at Time of Service	Care Provider Name (Complete section below)	Amount
Start Date	End Date				

Total Dependent Care Claim $_____

The information requested below for each care provider is required for reimbursement. (Please print.)

Name		**Name**	
Address		**Address**	
Tax ID Number		**Tax ID Number**	
Provider Signature		**Provider Signature**	

CERTIFICATION AND DATE

I authorize release of any information relating to this claim to IBM, its contract administrators, or their representatives, as necessary to determine the validity or amount payable on account of this claim. I agree that IBM's contract administrators may release to IBM, or any contract administrator designated by IBM, upon IBM's request, any records and information in its possession in connection with this claim.

I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse and/or eligible dependents, as defined in Internal Revenue Code Section 152) and that the descriptions of these expenses are accurate and meet the guidelines specified under Internal Revenue Code Sections 105 and 125, and supporting IRS Regulations.

A copy of the authorization shall be as effective as the original. I certify that all the information provided is true and correct and that none of the expenses submitted have been or can be reimbursed under any other plan or insurance. The dependent care expenses claimed are eligible employment-related expenses, will not be reimbursed under any other plan, and comply with the federal regulations governing the IBM Dependent Care Spending Account plan.

I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties, and will hold Acclaris harmless for payment of any ineligible expenses presented in such a manner. I also understand that for the Dependent Care Spending Account, only funds that I have already deposited into my account can be reimbursed. If the claim totals more than the amount existing in my account, I will be reimbursed for the amount in the account, and the remainder of the claim will be reimbursed as additional funds are deposited.

Signature of Participant: _____ **Date:** _____

(Please print the requested information below. Only the last four digits of your Social Security Number are required.)

Name: _____ Daytime Phone No.: ( )

Social Security Number: XXX-XX- E-Mail Address: _____