



# Flexible Spending Account Dependent Care Reimbursement

Send completed form and documentation to:

**Aetna FSA**  
**P.O. Box 4000**  
**Richmond, KY 40476-4000**  
**Fax to: 1-888-238-3539 (1-888-AET-FLEX)**

**For the hearing impaired, call 1-877-703-5572 TDD/TTY**

Please sign this form and either attach a signed receipt from a qualified caregiver or have the caregiver sign this form. See instructions on reverse side.

<b>1. Employee Information</b>	Identification Number	Name	Daytime Telephone Number (      )		
	Address (include zip code) <input type="checkbox"/> Check if address is new		Home Telephone Number (      )		
<b>2. Employer Information</b>	Employer Name		FSA Control Number		
<b>3. Dependent Information</b>	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age	
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		<b>Total Amount Submitted \$</b> _____		
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age	
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		<b>Total Amount Submitted \$</b> _____		
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age	
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		<b>Total Amount Submitted \$</b> _____		
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age	
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		<b>Total Amount Submitted \$</b> _____		
	Name	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Date of Birth (MM/DD/YYYY)	Age	
	Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		<b>Total Amount Submitted \$</b> _____		
	<b>4. Expenses for Before &amp; After Kindergarten</b>	Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
		Date(s) of Service (MM/DD/YYYY) From _____ Thru _____		<b>Total Amount Submitted \$</b> _____	
<b>[Note] Review eligibility information on page two.</b>					
<b>5. Caregiver Information</b>	Caregiver Name		Social Security Number or Tax ID Number of Caregiver		
	Address of Caregiver		Telephone Number of Caregiver (      )		
Relative <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Cancelled checks are not adequate documentation unless services are provided by a relative.**

<b>6. Employee/Caregiver Certification</b>	<p>I certify that I have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account, and I further declare that I have not and will not claim credit for these expenses on my individual income tax returns.</p> <p>I further certify that I have read and understand the limitations on reimbursement from my Flexible Spending Account on the reverse side of this form for dependent care expenses, and that I am eligible to receive benefits under this program.</p> <p>I also certify that the above dependent care expenses are for the care of a qualifying child or relative and do not include separate charges for food, clothing, education, entertainment, activities, late fees, transportation or overnight care. <b>Please review eligibility information on page two.</b></p>
<b>Sign Here ▶</b>	<b>Signature of Employee</b> _____ <b>Date</b> _____
<b>Sign Here ▶</b>	<b>CAREGIVER CERTIFIES</b> that I am a qualified caregiver as defined by the Internal Revenue Code and that the expenses for services claimed above have actually been provided. <b>Signature of Caregiver</b> _____ <b>Date</b> _____

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

## Instructions

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1. Complete all applicable sections.
2. If your claim submission is for more than four family members, please submit a separate claim form for each additional family member.
3. Use Aetna's Voice Advantage® Unit (AVA) to obtain current account balance and claim payment information (this toll-free number is available from your employer). AVA is available Monday through Saturday, from 7 a.m. to 12 midnight ET.
4. Items for which you are reimbursed cannot be claimed as deductions or credits on your federal income tax returns.

## Eligibility

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1. Your expenses for dependent care services are eligible for reimbursement only if the services are performed for the benefit of a "qualifying child or relative." A qualifying child or relative is:
  - a dependent of yours who is under the age of 13
  - your spouse or dependent, if he or she is incapable of self-care on a temporary or permanent basis
2. A "dependent" is someone you may claim as a dependent on your federal income tax return.
3. "Eligible dependent care services" include:
  - services for the care of a qualifying child or relative
  - in-home services that are related to the care of a qualifying child or relative

The expenses to be reimbursed must have been incurred to enable you or your spouse to remain gainfully employed during a period in which there was at least one qualifying child or relative residing in your household.

4. You cannot be reimbursed for expenses:
  - for service not yet received, even if paid in advance
  - incurred for transportation of a dependent to a dependent care center
  - paid to one of your dependents for whom an exemption is claimed on your tax return
  - paid to one of your children who is under the age of 19, even if not a dependent
  - for out-of-home care for a qualifying child, over the age of 13, unless the qualifying child spends at least eight hours per day in the employee's home
  - for kindergarten education (services provided for day care before and after school are eligible for reimbursement when listed separately)
5. If you use the services of a "dependent care center," the center must meet all requirements of state and local law. A "dependent care center" means any facility that provides care for more than six individuals (other than individuals who reside there) and receives a payment or grant for providing dependent care services.
6. If you are married, you will only be eligible for reimbursement of dependent care expenses if your spouse is also employed, looking for work, or if he or she is a full-time student or incapable of self-care.
7. Effective January 1, 2003, you may not claim dependent care expenses that exceed the lesser of:
  - \$5,000, or \$2,500 if married and filing separate returns
  - your earned income
  - if you are married, your spouse's income (If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have qualifying earnings for each month he or she is a full-time student or incapacitated. The amount of deemed earnings will be \$250 a month if you provide care for one qualifying child or relative or \$500 a month if you provide care for more than one qualifying child or relative). For deemed income amounts for years prior to 2003, please refer to the applicable edition of IRS Publication 503.