



# DEPENDENT CARE

## Flexible Spending Arrangement Claim Form

Apply expenses to the

20 \_\_\_\_ Plan year

Claims may be faxed to: 916-605-4013, or scanned and emailed to: [claims@125max.com](mailto:claims@125max.com)

### Participant Data

|   |                                      |
|---|--------------------------------------|
| <b>Employer Name:</b>   |                                      |
| Participant Name:   |                                      |
| Participant Social Security:  | XXX – XX – Last four (4) digits only |
| Daytime Phone Number:   | (     )     -                        |
| Evening Phone Number:   | (     )     -                        |
| E-Mail Address: Work <input type="checkbox"/> Home <input type="checkbox"/> |                                      |
| Change of Address: <input type="checkbox"/>                                 |                                      |
| Change of Phone Number: <input type="checkbox"/>                            | (     )     -                        |
| Change of e-mail address: <input type="checkbox"/>                          |                                      |

### Reimbursement Request

Complete the following grid for each dependent care expense submitted for reimbursement. In order to receive reimbursement, appropriate supporting documentation must accompany this form. Please refer to the 125MAX Information and Instructions and the 125MAX Participant User's Guide to confirm necessary documentation, timing requirements and rules for eligible expenses.

| Name of Dependent | Relationship to Employee | Dependent Date of Birth | Period for Expense Reimbursement | Name of Dependent Care Provider | Provider Tax ID# | Total Expense for Period |
|-------------------|--------------------------|-------------------------|----------------------------------|---------------------------------|------------------|--------------------------|
|                   |                          |                         | From:<br>To:                     |                                 |                  | \$                       |
|                   |                          |                         | From:<br>To:                     |                                 |                  | \$                       |
|                   |                          |                         | From:<br>To:                     |                                 |                  | \$                       |
|                   |                          |                         | From:<br>To:                     |                                 |                  | \$                       |

**Provider Signature:**

**Date:**

### Participant Certification

To the best of my knowledge and belief, the statements in this dependent care expense claim form are complete and true. I certify these expenses are for valid dependent care services provided on the dates indicated and that these expenses were incurred during the Plan Year in which I was an active participant in the 125MAX Dependent Care Flexible Spending Arrangement. *These expenses have not been reimbursed under the 125MAX plan previously nor have they been reimbursed under any other dependent care plan. Additionally, I will not seek reimbursement elsewhere in the future.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

Date:     /     /

Participant Signature:

**A photocopy of this form may be used if needed.  
Be sure to include proper documentation to avoid delays in your reimbursements.**