Flexible Spending Account
Dependent Care Reimbursement Claim Form

Employer_____

Name_____ Social Security #_____

Dependent Care Expense Claims

Name of Dependent(s)	Period Covered From	To	Name, Address & Taxpayer ID No. of Provider of Service	Amount Incurred
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's Signature Date

Mail or Fax claims to:
Cornerstone Administrative Services
Attention: Flex Claims Department
1350 Division Road, Suite 301, West Warwick, RI 02893
Phone: (800) 720-4460 ~ Fax: (866) 878-2800

(**You may copy this form if additional forms are needed**)