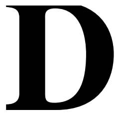

Flexible Benefits Plan

DEPENDENT CARE Reimbursement Request

PLEASE PRINT CLEARLY **CROSBY BENEFIT SYSTEMS, INC.**

Employee Information

CHECK BOX IF NEW ADDRESS ☐

Please also notify employer of any address changes.

Employee Name ______________________________ Harvard ID # ________________
Last First MI

Employer **HARVARD UNIVERSITY / HBSPC** Email address ________________________

Home Address ____
Street City State Zip

Home Phone No. (______)________________ Work Phone No. (______)____________________
area code area code ext.

Expenses

Please list all out-of-pocket dependent care expenses for which you are requesting reimbursement.

Description of Expense	Date of Service	Amount

TOTAL EXPENSES $__________

Include with this form all "Supporting Documentation" as defined in the Important Information section on the reverse side of this form. Retain a copy for your records. Canceled checks are not acceptable. Failing to submit Supporting Documentation will delay (or prevent) claims processing.

Employee Certification

By signing below, I hereby certify the following:

- The expenses listed above are "Eligible Employment Related Expenses" as defined in the Summary Plan Description ("SPD"). See reverse side for general information regarding Eligible Employment Related.
- The expenses are for the custodial care of one or more "Qualifying Individuals" as defined in your SPD. (Note: See reverse side for general information regarding "Qualifying Individuals".)
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I have obtained or made reasonable efforts to obtain the provider's taxpayer identification number ("TIN") and I will include that TIN on the Form 2441 that I attach to my federal income tax return.
- If the provider is a dependent care center which provides care for six (6) or more individuals, the center complies with all applicable state laws.

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Please SIGN

Employee Signature ________________________________ **Date** ________________

- **Claims for Eligible Dependent Care Expenses incurred during the 2008 plan year (1/1/08 – 3/15/09) MUST BE POSTMARKED by March 31, 2009.**
- **Claims for Eligible Dependent Care Expenses incurred during the 2009 plan year (1/1/09 – 3/15/10) MUST BE POSTMARKED by March 31, 2010.**