DEPENDENT CARE SPENDING ACCOUNT

Form Filing Instructions for Reimbursement

Important Information

- ✓ Only eligible expenses incurred during your spending account plan year, and while you are an active participant, are eligible for reimbursement.
- ✓ An expense is incurred when the service is provided – not when you are billed or pay for the service.
- ✓ Any unpaid Dependent Care amounts (due to expenses exceeding the amount in your account at the time of the claim) will be paid out automatically as money accumulates in your account. You do not need to resubmit the claim.
- ✓ You will receive an account summary with each reimbursement in addition to quarterly account statements.
- ✓ You will have until June 30, 2018, to submit your claims and documentation for expenses incurred while you are a participant during 2017. Any claims submitted via fax or postmarked after June 30, 2018, will not be reimbursed.
- ✓ For more information and important rules, read the "Spending Accounts" section of the Summary Plan Description (SPD). The SPD is available online at **mylacountybenefits.com**. Select "View the Summary Plan Description" in the "my resources" menu.

How to Submit Your Claims Online

When you use **mylacountybenefits.com** to submit your claims, you'll do less paperwork and typically receive your reimbursements more quickly.

1. Go to mylacountybenefits.com and select "Spending Accounts" in the "my resources" menu.
2. Fill out the claim information online.
3. Attach scans of your proof of expenses or follow the on-screen instructions to fax or mail them.

The online system also allows you to check the status of your claims, see your account balance and more. Give it a try. It's fast and easy.

Reimbursement Instructions

1. After you have incurred an eligible expense during the plan year, complete a claim form. You will be reimbursed for eligible expenses up to the amount you have deposited in your account to date (through your payroll deductions) minus any previous reimbursements. Qualifying dependent care expenses include expenses paid:

- To a dependent care center or care provider.
- For the care of a dependent under age 13.
- For the care of other dependents who are your dependents for federal tax purposes and are physically or mentally incapable of caring for themselves. These dependents must live with you at least eight hours per day if their care is provided outside the home.

2. Present this form to your Dependent Care provider to have them complete the Dependent Care Claim Substantiation Statement (you will need to complete the rest of the form), **OR**:

- Include photocopies of your proof of expense documentation with this claim form. Do not staple receipts to the form and **DO NOT send original receipts**.
- All proof of expense documentation must be received in an 8 ½" x 11" format. **Your claim form and documentation will be returned to you if it is not in this format.**
- Proof of expense must contain the following pieces of information:
  - Date of Service
  - Provider Name
  - Expense Type
  - Relationship
  - Miles to provider and back
  - Amount Requested

  In lieu of submitting the information above, you may submit an Explanation of Benefits (EOB) from the insurance carrier.
- Cancelled checks and credit card statements/receipts are not considered to be valid proof of expense.

3. Fax or mail this claim form, completed and signed, along with the appropriate documentation to 866-629-6390 or to the address found at the top of the page on the other side of this claim form.

4. If you have questions about completing a claim form, eligible expenses or about your spending accounts in general, call Benefit Concepts at 866-629-6436, Monday through Friday, 5:30 a.m. to 6:30 p.m. Pacific time.

FSA-DEP
Spending Account Administrator
P.O. Box 67128
Los Angeles, CA 90067
Fax: 866-629-6390
mylacountybenefits.com

DEPENDENT CARE SPENDING ACCOUNT CLAIM FORM

Employer Information

County of Los Angeles

Employee Information

First Name:	**Last Name:**	**Last Four Digits of Social Security Number:**
Address:	**City:**	
State:	**Zip Code:**	**Work Phone:**

Dependent Care Expenses

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Service Start Date:	**Provider:**	
Service End Date:	**Expense for Name:**	**Dependent Date of Birth:**

Expense Type:
☐ Day Care ☐ Before/After School Program
☐ Day Camp ☐ Other: _____

Relationship To Employee:
☐ Dependent Child(ren) _____
☐ Other: _____

Amount Requested:
$

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Service Start Date:	**Provider:**	
Service End Date:	**Expense for Name:**	**Dependent Date of Birth:**

Expense Type:
☐ Day Care ☐ Before/After School Program
☐ Day Camp ☐ Other: _____

Relationship To Employee:
☐ Dependent Child(ren) _____
☐ Other: _____

Amount Requested:
$

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Service Start Date:	**Provider:**	
Service End Date:	**Expense for Name:**	**Dependent Date of Birth:**

Expense Type:
☐ Day Care ☐ Before/After School Program
☐ Day Camp ☐ Other: _____

Relationship To Employee:
☐ Dependent Child(ren) _____
☐ Other: _____

Amount Requested:
$

Total Reimbursement Requested: $

Dependent Care Expense Certification

I certify that all services for which reimbursement is requested under the County of Los Angeles Dependent Care Spending Account were incurred within the Plan Year of my election and that the expenses associated with these services have been paid by me. I will not use expenses reimbursed through my dependent care assistance account as deductions when filing my Federal Income Tax return.

Signature: _____ **Date:** _____

Dependent Care Claim Substantiation Statement

I hereby substantiate the claims listed above.

Provider Name:	Provider Tax I.D. Number:
Provider Address:	
Signature:	Date: