Plan Year: _____
Dependent Care Assistance Program Registration Statement

PO Box 587
Pittsford, NY14534
Phone: (800) 836-8100
Fax: (585) 248-2488

PLEASE read prior to completing the Dependent Care Assistance Program Registration Statement:

- ✓ **A qualifying dependent for the Dependent Care Assistance Plan is a dependent child UNDER THE AGE OF 13 or a spouse or other dependent adult who is not able to care for him or herself.**
- ✓ Dependent care expenses must be utilized for the specific purpose of allowing both you and your spouse to work (unless disabled, physically or mentally incapable of self-care, attending school full-time or actively seeking employment).
- ✓ Payments for care cannot be paid to someone you can claim as your dependent on your tax return or to a child who is under age 19.
- ✓ You must be able to claim the child as an exemption on your tax return. For an exception see Section 152(e) of the Internal Revenue Code concerning dependents of divorced or separated parents or parents who live apart.
- ✓ Valid expenses include child day care, nursery school, before- and after-school care, adult care, and in-home dependent care. Tuition for Kindergarten and higher is not a valid expense. *Overnight Camps and Sports Training/Lessons are NOT Eligible.*
- ✓ Internal Revenue Code Section 129 limits the maximum election amount to $5,000 ($2,500 for married filing separately) OR the employee's earned income (if less than $5,000/$2,500) OR the spouse's earned income (if less than $5,000/$2,500)
- ✓ THIS IS NOT AN ENROLLMENT FORM

***Please note that claims will not be paid without a Dependent Care Registration Statement on file.**
A new form must be completed each year. All sections MUST be completed.

Employee Required Information (Please Print)

EMPLOYER:

EMPLOYEE NAME:

Employee SSN: X X X ■ X X ■ ☐ ☐ ☐ ☐

Address: City: State: Zip:

Email Address:

Marital Status: ☐ Single ☐ Married ☐ Divorced

Spouse Required Information (Please Print)

Spouse's Name:

Spouse's Employer:

If Spouse is NOT employed: Is Spouse incapacitated? ☐ Yes ☐ No
Is Spouse a full-time student? ☐ Yes ☐ No (If yes, please complete the following)

Name of Institution (If Applicable):

Months of Attendance (If Applicable):

Dependent Required Information (Please Print)

Name	Relationship to Employee	Date of Birth

Do you have custody AND pay the day care expenses for the above-named dependent(s)?	☐ Yes ☐ No
If you are using dependent day care coverage under the Flexible Benefits Plan for your spouse and/or other tax dependents OVER the age of 13, is that person physically or mentally incapable of caring for him or herself?	☐ Yes ☐ No
In reference to the above questions, does the qualifying dependent spend at least eight (8) hours per day in the employee's household?	☐ Yes ☐ No

If you have any questions regarding this form or your account, please contact us at:
800.836.8100 or info@flexbene.com

Updated Nov-20

Dependent Day Care Provider Information (Please Print)

Name of Service Provider:			
Address:	City:	State:	Zip:
Tax Identification Number / Social Security Number:			
Relationship to Employee:	Type of Services Provided:		
Location Where Services will be Performed:			
If services are being provided at a day care center (i.e., a facility that provides for more than six (6) individuals not residing at the center), does the day care center comply with all applicable state laws and regulations?			☐ Yes ☐ No
If service is being performed by one of your children, how old is the child? (Anyone under the age of 19 is not an eligible service provider.)			**Age** _____
Annual Cost of Services: $ _____			

Additional Dependent Day Care Provider Information (Please Print)

Name of Service Provider:			
Address:	City:	State:	Zip:
Tax Identification Number / Social Security Number:			
Relationship to Employee:	Type of Services Provided:		
Location Where Services will be Performed:			
If services are being provided at a day care center (i.e., a facility that provides for more than six (6) individuals not residing at the center), does the day care center comply with all applicable state laws and regulations?			☐ Yes ☐ No
If service is being performed by one of your children, how old is the child? (Anyone under the age of 19 is not an eligible service provider.)			**Age** _____
Annual Cost of Services: $ _____			

I certify that the foregoing information is correct and true to the best of my knowledge.

I agree to inform Flexbene immediately of any change in the foregoing information.

Employee Signature: _____ Date: _____