IAS | INSTITUTE FOR ADVANCED STUDY

DEPENDENT CARE CLAIM FORM

Employee Name _____

I request reimbursement from my Dependent Care Account for the following:

1. Name of Dependent(s) _____
2. Age of dependent if a child _____
3. Period covered: From _____2020 through _____ 2020
4. The employer identification number (EIN) or social security number of the person providing the service: _____
5. Name and Address of person providing service:

   _____

   _____

   TOTAL AMOUNT CLAIMED $ _____

NOTE: The total amount claimed under the plan for any coverage period must not exceed the lesser of a) your wages for the plan year; b) the wages of your spouse; or c) $5,000 ($2,500 if you are married but filing income tax forms separately). If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one child or dependent, and $500 if there are two 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.

Please read carefully:

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Benefit Expense Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for such payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including Federal or FICA tax on amounts paid from the plan which relate to such expense.

_____ _____

Date Signature

2524-0000-1