

DEPENDENT CARE EXPENSE CLAIM FORM

Mail to:
 UPMC Health Plan
 PO Box 3169
 Greenwood Village, CO 80155-3169

Phone: 1-888-876-2756
 Fax: 1-866-229-3711

No. of pages _____

PLAN & EMPLOYEE INFORMATION

FIRST NAME: _____ LAST NAME: _____ MEMBER ID NUMBER: _____

DAYTIME PHONE : (_____) _____ EMAIL: _____ DATE OF BIRTH: ____/____/____

EMPLOYER NAME: _____ PLAN YEAR: _____

Note: Reimbursements will be sent to the address on file with UPMC. If an address change or update is needed, please contact your Human Resources administrator to update.

DEPENDENT CARE EXPENSES

PLEASE DO NOT HIGHLIGHT ITEMS ON THIS FORM IF YOU WILL BE FAXING

| PROVIDER NAME | *PROVIDER TAX ID # | PROVIDER ADDRESS, CITY, STATE & ZIP | START DATE | END DATE | NAME OF DEPENDENT | AMOUNT |
|--------------------------------------------------------------------------------------------------------|--------------------|-------------------------------------|------------|----------|-------------------|-----------------------|
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| * Your claim cannot be paid without a Provider Tax ID Number or Provider Social Security number | | | | | | TOTAL EXPENSES |

If your employer has adopted the grace period (IRB 2005-42), expenses incurred during that period (typically 75 days after the plan year ends) are eligible for reimbursement from either the current or the previous FSA plan year. If you are seeking reimbursements for expenses incurred within that period, please mark one of the boxes below to indicate that plan year from which you would like to be reimbursed. If you do not mark one of the boxes, the previous plan year's balance will be exhausted.

Reimburse from previous plan year
 Reimburse from current plan year

REIMBURSEMENT INFORMATION

UPMC Health Plan will process your reimbursement according to the banking method we currently have on file, either check or direct deposit*. If you would like to make a change, you must submit a completed Reimbursement Authorization Agreement, which can be found on the forms section of your Participant Portal. Log in to www.upmchealthplan.com/myflex. Your reimbursement method will remain in effect until an updated authorization form has been received and processed by UPMC Health Plan, which may take up to 10 business days. To ensure your claim is being paid using the method of your choice, it is advisable to submit changes well before submitting a request for reimbursement.

Direct deposits normally take 2 business days from the date of initiation. Bank holidays/ weekends may affect when the deposit is credited to your account. Please contact your bank to verify all deposits are received. If you provide us with your email address we will inform you each time a direct deposit is initiated. Direct deposits cannot be posted to debit or credit cards. Any direct deposit remitted by UPMC Health Plan and not rejected by your bank is deemed a valid reimbursement and will not be adjusted. There may be a \$25 fee to reissue lost/ stolen checks.

* Direct deposit is not offered as an option under all plans. If your plan does not offer direct deposit, a check will always be issued for your reimbursements.

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these dependent care expenses have not already been reimbursed under this plan or any other plan and will not be reimbursed under any other employer plans or coverage. I certify that these expenses have not been paid to anyone who is my child or stepchild under the age of 19 and claimed as a dependent on my income tax return. **I understand that I am responsible for acquiring and retaining receipts from my provider for services claimed under this plan. I further understand that I am responsible for reporting the Tax ID# provided above on IRS Form 2441 when I file my Federal Income Taxes.** I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand.

Signature: _____ Date: _____