DEPENDENT CARE REIMBURSEMENTS

WE MAKE IT EASY TO GET REIMBURSED

It sure is easy.

This document will help you choose between two reimbursement options for your Dependent Care Expenses. Use the form on Page 2 to request your reimbursement.

IMPORTANT INFORMATION ABOUT SERVICE PERIOD AND EXPENSE REIMBURSEMENTS

The IRS has strict requirements for reimbursements for dependent care expenses. Dependent care expenses must be fully "incurred" prior to receiving reimbursement which means that dependent care services must have been fully provided and completed for the service period before you are reimbursed for your dependent care expenses. This is an important point to remember because most providers require prepayment of dependent care services at the beginning of the service period before they provide dependent care services. In order to follow IRS' requirements, you may only be reimbursed at the end of the service period even if you prepaid the provider for dependent care services.

For example: Jane has a young daughter, Amy, in daycare. Jane uses daycare services so she can work full-time Monday through Friday. She pays her daycare provider weekly on Mondays. When Jane takes Amy to daycare on Monday, January 2, she pays the provider for the week. The dependent care service period from which she is paying is Monday, January 2, through Friday, January 6. Jane is pre-paying for dependent care services because she pays on Monday, but the service period is not complete until Friday, January 6.

According to the IRS, Jane cannot receive reimbursement for this dependent care expense until January 7, after the full service period (January 2 - 6) has ended and all services have been provided in full. It is at this point that expenses are considered fully "incurred".

NOTE: Claims submitted for future dates may be denied and will need to be resubmitted at a later date.

CHOOSE YOUR REIMBURSEMENT METHOD

1 – RECURRING DEPENDENT CARE REIMBURSEMENT

With Surency you can submit one claim form for the entire year and receive recurring reimbursements. Choose this option if your dependent care expenses are for the same amount, from the same provider and for the same length of time. For example, if your child attends a day care five days a week and the costs are the same each week, you can choose this reimbursement method.

2 – INDIVIDUAL CLAIMS REIMBURSEMENT

You may request reimbursement after you've incurred the dependent care expense and the funds have been withdrawn from your paycheck. Choose this option if you prefer to submit claims throughout the year or if your day care expenses vary throughout the year. For example, if your child attends a day care for part of the year and an after school program for part of the year.

WANT TO GET PAID BACK AUTOMATICALLY?

Sign up for Direct Deposit and after you submit a claim, Surency will automatically deposit those dollars back into your bank account. There are two ways to set up Direct Deposit:

1. **MEMBER ACCOUNT AT SURENCY.COM**
   Log into your Member Account at Surency.com to input bank information.

2. **PAPER DIRECT DEPOSIT FORM**
   Visit Surency.com to download a Direct Deposit form. Complete and return to Surency.

866-818-8805 | Surency.com

Surency Flex is administered by Surency Life & Health Insurance Company.
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DEPENDENT CARE REIMBURSEMENT FORM

Last Name, First Name, MI (Please Print) ____________________

Employer ____________________

Social Security Number or Employee ID ____________________

Street Address ____________________

City, State, ZIP ____________________

☐ Check if NEW ADDRESS

Requesting Reimbursement for: ☐ Recurring Reimbursement Fill out sections 1 and 2. ☐ Individual Claim Reimbursement Fill out sections 1 and 3.

Section 1 - Dependent Information

Dependent care expenses must be for a dependent that is incapable of self-care or under the age of 13 at the time the care was provided

Dependent Name	Date of Birth	Name and Address of Care Provider	Provider ID/SSN

Section 2 - Recurring Reimbursement

Dependent Care Provider Information (to be completed by the provider only) Rates are effective (start date): ____________________to (end date): ____________________

The provider charges: $ ____________________ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please describe fees):____________________

By signing this, I certify the information I provided above is accurate and I understand the information is to substantiate the name of the dependent care provider, the dates of dependent care services rendered by the dependent care provider, and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

Provider's Signature (required): ____________________ Date: ____________________

Member Authorization and Signature

This form eliminates the need for additional documentation for recurring dependent care expenses in the same amount from the same provider for the same service period lengths. Please note: hourly or variable rates cannot be set up as recurring expenses. I understand that I will need to promptly complete and submit a new request form if any of the provided information above changes. This form is valid for the rate duration listed above, or the current Plan Year, whichever is shorter. As payroll deductions are received, Surency will automatically generate reimbursements for recurring expenses after the date they are incurred as provided above.

To the best of my knowledge, the provided information above is complete and true. I am claiming reimbursement only for eligible expenses incurred for eligible plan participants during the applicable Plan Year. I certify that I have not been previously reimbursed for these expenses and that I will not seek reimbursement from any other source. I should retain a copy of all submitted documentation in the event of an IRS audit. I understand that Surency, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement or the provided information is not complete or true. I authorize my Dependent Care Flexible Spending Account to be reduced by the amount requested on a recurring basis as provided above.

Employee's Signature (required):____________________ Date: ____________________

Section 3 - Individual Claim Reimbursement

Dependent Name	Dates Care Provided		Amount Requested
	From	To	
		TOTAL	

I provided the dependent care as stated above: Provider's Signature (required): ____________________ Date: ____________________

Member Authorization and Signature

I hereby certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other sources. I also understand that Surency , its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement . I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Employee's Signature (required):____________________ Date: ____________________

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773
866-818-8805 | Surency.com

Surency Flex is administered by Surency Life & Health Insurance Company.

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