Integrity Administrators, Inc.

INTEGRITY ADMINISTRATORS, INC.

DEPENDENT CARE ACCOUNT PLAN (DCAP)

REIMBURSEMENT REQUEST FORM

Employer: _____

Employee Name & Address

Last Name: _____ **First Name:** _____ **M. I.** ____ ☐ **Male** ☐ **Female** **Phone #:** (____) ____-____ **Employee # or SSN #:** ____/____/____

Street: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Instructions: *Complete the information below for Dependent Care expenses incurred by you or your spouse for which you are requesting reimbursement. For information as to what Dependent Care Expenses can be reimbursed, see the Salary Reduction Plan Summary Description. You must provide bills, receipts, or other evidence from your dependent care provider or other evidence that Expenses were incurred (cancelled checks or balanced due bills are not acceptable). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you.*

	Expense #1	**Expense #2**	**Expense #3**	**Expense #4**	**Expense #5**	**Expense #6**
Date(s) dependent care service was actually provided:	_____To_____	_____To_____	_____To_____	_____To_____	_____To_____	_____To_____
Name & Age of dependent:	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Proof of expense attached:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Reimbursement Requested:	$	$	$	$	$	$
					Total Reimbursement Requested:	**$**

DEPENDENT CARE SERVICE PROVIDER'S VERIFICATION:

Name: _____ Tax I.D. Number: ____-____ or Social Security Number: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

X: _____ _____

Provider's Signature Date

I authorize the above expenses to be reimbursed from my DCAP Account. To the best of my knowledge, my statements on this form are true and complete. I certify all of the following: My family member has received the services described above on the dates indicated, and the expenses qualify as valid Dependent Care Expenses as defined in the Salary Reduction Plan document ("The Plan"). The expenses listed are for a Qualifying Individual as defined in the Plan. These expenses have not previously been reimbursed under the DCAP or any other plan, and I will not seek reimbursement for them under another insurance or any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Tax Credit.) I agree to file IRS Form 2441 with my tax return and provide taxpayer identification numbers. I also understand that any reimbursement I receive for these expenses cannot be excluded from my income to the extent that the reimbursement, when added to excludable reimbursements to date for Dependent Care Expenses incurred during the same calendar year (from any plan), exceeds the statutory limits described in the Salary Reduction Summary Plan Description. I have read, understand, and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Form.

X: _____ _____

Employee Signature Date

Please Make Sure to Sign and Date This Form, Then Send It or Fax It Along With Your Supporting Documentation To:

Integrity Administrators, Inc.
P.O. Box 13128 Sacramento, CA 95813
(916) 921-3388 (800) 562-9383 Fax: (916) 921-3383

Integrity
Administrators, Inc.

INTEGRITY ADMINISTRATORS, INC.

CERTIFICATE OF QUALIFYING DEPENDENT CARE EXPENSES

By signing and submitting this DCAP Reimbursement Request Form, you are certifying that expenses for which you request reimbursement satisfy all of the following conditions. Capitalized terms used in this Form have the meanings described in the Salary Reduction Plan.

- Each person for whom you incur the expenses must be a Qualifying Individual. That is, he or she must be:
  - A person under age 13 who is your "qualifying child" under the IRS Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them: and (3) does not provide more than half of his or her own support for the year);
  - Your Spouse who is physically or mentally incapable of self-care and has the same principal abode as you for more than half the year; or
  - A person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code or would qualify as your tax dependent except that: (1) he or she has an income that equals or exceeds the exemption amount; (2) he or she is married and files a joint return with his or her spouse; or (3) you (or your Spouse, if filing jointly) could be claimed as a dependent of another taxpayer.

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the non-custodial parent is entitled to claim the dependency exemption for the child.

- No reimbursement will be made to the extent that the amount of such reimbursement is larger than the balance remaining in your DCAP Account.
- The expenses must be incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses must be incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, then he or she must be a full-time student or be physically or mentally incapable of self-care.
- The expenses must be incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), then the center must comply with all applicable state and local laws and regulations.
- The person who provided care cannot be your Spouse, a parent of your under age 13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code §151 (c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses cannot be paid for services outside of your household where the Qualifying Individual stays overnight.
- You must have no reason to believe that the requested reimbursement when, added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed your applicable statutory limit. Your statutory limit is the smallest of the following amounts:
  - Your earned income for the calendar year (after your salary reductions under the Salary Reduction Plan);
  - The earned income of your Spouse for the calendar year. Your Spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals) for each month in which your spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student; or;
  - Either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described further in the Salary Reduction Plan Summary Description.

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