Advanced Benefit Strategies
Your Flexible Benefits Specialists

Automatic Dependent Care Reimbursement Affidavit

I. Employee Information

Your Employer	Your Name
( ) Day time telephone number	Social Security Number

II. Certification from Dependent Care Provider – this box must be complete

I, the Dependent Care Provider listed below, certify that I will provide the services as listed below. I understand that I will be required by the IRS to pay taxes on the payment for these services.

Signature: _____Date: _____

Provider Tax ID # or Social Security # _____

Amount per week: $_____ and for how many weeks?_____

Date of service beginning?_____ and ending on _____

OR

Amount per month: $_____ and for how many months? _____

Date of service beginning?_____ and ending on _____

EXAMPLE: 1 week @$250.00 for 16 weeks for summer care or 1 month for $750.00 for 6 months of daycare.

Documentation must be attached to verify this submission. We require the following:

1) The signature of your day care provider in the above box.
2) A bill or statement that notes the name and address of provider.
3) List dates of service of the recurring expense (example – Jan 1, 2011 to Dec 31, 2011).

I understand that I can only be reimbursed for services with funds that have been posted to my Dependent Care Account and that reimbursements will be made payable to me with a check or direct deposit. I understand that I am responsible to pay my daycare provider.

I understand it is my responsibility to notify ABS if my daycare situation changes (example- a change in dependent care provider or a change in election amount). My employer is responsible for reporting the amount withheld from my pay for dependent care expenses on my year-end W-2. I understand that I must disclose this amount to the IRS when filing my annual tax return. If I fail to provide accurate information, I understand I may be subject to penalties in the event of an audit by the IRS.

IV. Certification

I certify that the above reimbursement submission is for expenses incurred for my eligible dependent.

Signature: _____ Date: _____

Fax to: 860-673-2207
Mail to: Advanced Benefit Strategies
30 Mill Street
Unionville CT 06085

Questions?
Call 860-675-2261
Toll Free 877-732-8125
Or, visit our web site @**www.abs125.com**