Dependent Daycare Reimbursement Request and/or Provider Acknowledgement Form

Clear Form

Complete this form to meet the requirements for documenting your day care expenses. This form, once completed, may act as your receipt for expenses incurred.

INSTRUCTIONS

Complete all sections of this form. Remember to sign and date the bottom of this form.

1. **Ask** your provider to complete Section C of this form if a daycare receipt is not available.
2. **If you are unable to attach your form or document to an online or mobile app claim or alert**, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:
   - Email to flex@goigoe.com
   - Fax to 800-456-9083
   - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
3. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Dependent Care/Day Care Expenses Incurred

Clear Section B

Service Date (mm/ dd/ yy)	Dependent Information Name, Age, Relationship	Description of Expense	Name of Provider	Provider's Tax ID or SSN	Net Amount
-					$
-					$
-					$
				Total Dependent Care	$ 0.00

Section C: Provider Acknowledgement (To be completed by the daycare provider if a separate receipt is not available)

I hereby acknowledge that the above listed services were provided in compliance with any applicable federal, state and local regulations governing dependent day care centers. I further acknowledge that the dates covered, dependent information, description of the expense, name of the provider, and provider's Tax ID or SSN as listed above are correct.

Provider's Signature: Ready to sign? Click to print ***Date:*** _____

Section D: Authorization *REQUIRED (PLEASE SIGN AND DATE)

I certify that I am a participant in the plan from which I am requesting reimbursement and that all expenses listed with this claim were incurred during my active participation in said plan. I certify that these expenses have not been and will not be reimbursed under any other benefit plan or charged to my employer's Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information herein. I further acknowledge that each expense listed above must be a proper expense under the plan. If not, I understand that I may be liable for the payment of all related taxes including federal, state or city Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE. Having agreed to all of the proceeding statements, I authorize the account associated with the plan selected to be reduced by the amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

Employee Signature: Ready to sign? Click to print

Date: _____