Advanced Benefit Strategies
Your Flexible Benefits Specialists

Yearly Automatic Dependent Care Reimbursement Affidavit

1) Have your day care provider **sign** this form in box II. REQUIRED
2) **Attach** a bill or statement that notes the name and address of provider. REQUIRED
3) **List** dates of service of the recurring expense (example – Jan 1, 20__ to Dec 31, 20____). REQUIRED
4) **COMPLETE A NEW FORM EACH NEW PLAN YEAR.**

I. Employee Information

Your Employer	Your Name
Day time telephone number	Social Security Number (or Employee ID if applicable)

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.

Signature: _____ Date: _____

Provider Tax ID # or Social Security # _____

The cost for dependent care service charged to me is as noted below: **Choose one**.

- ☐ Weekly - Amount paid per week: $_____ Number of weeks _____ Total: $_____
- ☐ Monthly - Amount paid per month: $_____ Number of months _____ Total: $_____
- ☐ Quarterly - Amount paid per quarter: $_____ Number of quarters _____ Total: $_____
- ☐ Yearly - Amount paid per year: $_____ Total: $_____

The date of service will begin on _____ and end on _____ (enter a complete date in each section.)

EXAMPLE: $100.00 per week for 48 weeks = $4,800.00

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: _____

Mail to: Advanced Benefit Strategies
30 Mill Street
Unionville CT 06085

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Or, visit our web site @**www.abs125.com**