DEPENDENT CARE REIMBURSEMENT REQUEST FORM

Name: ______________________ SS#: ______________ Employer Name: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Home Phone #: ______________________ Work Phone #: ______________________

INSTRUCTIONS: Complete ALL information below for dependent care expenses for which you request reimbursement and certify that these expenses were incurred so you and/or your spouse can work or look for work. **You must provide receipt of payment from your dependent care provider (canceled checks will not be accepted).** Return this signed and dated form with supporting documentation to the fax number or address below.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Dependent Care Service Provided	**10/7/01/ to 10/14/01**	________ to ________	________ to ________	________ to ________	________ to ________
Name and Age of Dependent	**Fred Jones Age 4**				
Name and Address of Provider & TIN# or SS#	**Day Care Inc. 123 Main St. Anytown, TX TIN# 74-12345**				
Total Expense	**$250.00**	$	$	$	$
Reimbursement Requested	**$250.00**	$	$	$	$

Total Amount Claimed: $

To the best of my knowledge and belief, my statements in this Dependent Care Reimbursement Request Form are complete and true. I understand that these dependent care expenses may not be used to claim any Federal Income Tax deductions or credit (including the Dependent Care Tax Credit). I agree to file IRS form 2441 with my tax return and provide any taxpayer identification number required thereon. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance will be forfeited and will remain with the employer at the end of the Plan Year.

______________________ ______________ ______________________

Employee Signature Date Email Address

NATIONAL PLAN ADMINISTRATORS, INC.
P.O. BOX 161630
AUSTIN, TX 78716
PHONE: (512) 327-6481 or (800) 880-2776
FAX: (512) 327-1027 or (800) 982-8140

QUALIFYING DEPENDENT CARE EXPENSES

The Cafeteria Plan Document contains the rules governing what expenses are covered. By signing and submitting this Dependent Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet all the following conditions:

1. The expenses are incurred so you (and your spouse, if you are married) can work or look for work.
2. The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of:
   (A) your earned income; or
   (B) if you are married, your spouse's actual or deemed earned income.
3. Each dependent for whom you incur the expenses is:
   (A) a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return, or
   (B) your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of caring for him or herself.
4. The expenses are incurred for the care of a dependent, or for related incidental household services.
5. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 3(A) above (or who is described in 3(B) above and regularly spends at least 8 hours per day in your household).
6. If the expenses are incurred for services provided by a dependent care center (i.e. a facility that provides care for more than 6 individual not residing at the facility), the center complies with all applicable state and local laws and regulations. Expenses are not paid for services at a camp where the dependent stays overnight.
7. The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.

CLAIM SUBMISSION PROCEDURES

Claim forms are available online at www.natlplan.com/forms.htm. In addition, you will receive a new claim form each time you are issued a reimbursement check.

According to the Internal Revenue Code Section 125, the Unreimbursed Medical and Dependent Care Flexible Spending Accounts (FSAs) may reimburse an expense if the participant provides

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred,
- The amount of such expenses(s)

Procedures for submitting claims that will help to ensure prompt and efficient processing:

1. ALL receipts submitted for Dependent Care expenses must include the following information:
   - Date(s) of service,
   - Name(s) of the person(s) for whom the service was provided,
   - A breakdown of all charges or services,
   - Provider's name and address,
   - Provider's tax identification number or social security number,
   - Total amount of payment for which you are seeking reimbursement.
2. No reimbursements on advance payments for Dependent Care can be made.
3. Dependent Care Claims will be reimbursed according to the amount available in your flexible spending account at the time your claim is processed.
4. **Please be sure to retain copies of all items submitted to NPA for reimbursement.**