CPI

Flexible Spending Account

Dependent Care Claim Form

Employer: _____ ***Plan Year:*** _____

Participant: _____ ***Last Four of SSN:*** ***XXX-XX-*** _____

Address: _____

City, State, Zip Code: _____

Phone: _____ ***Email:*** _____

An eligible dependent, in general, is a "qualifying child: or a "qualifying relative":

- **Dependent child under age 13**
- **Spouse or dependent who was not physically or mentally able to care for himself or herself and lived with you for more than half the year.**

Reference IRS Publication 503 for a full explanation of a qualifying dependent. Also, consult your legal or tax advisor regarding your specific situation, as rules can vary for children of divorced or separated parents, etc.

Claim Amount: *$*_____ ***Dates of Service*:** _____

Dependent Information:

Dependent Name	Relationship	Date of Birth

Day Care Facility or Individual who provides care:

Name	Address	Tax ID

- ***All claims require copies of bills/statements/receipts that include the dates of service****
- ***Cancelled checks, bank statements, and credit card receipts are not adequate.***
- ***Expenses must be incurred during the plan year noted at the top of this form. For terminated employees, claims must additionally be incurred prior to the date of termination of employment.***
- ***Reimbursements are issued weekly. Direct deposits will occur on Monday for claims approved prior to Thursday of the preceding week. Checks are issued and mailed on Fridays for claims approved prior to Thursday of that week.***

**The dates the child was in the care of the daycare provider/facility.*

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's cafeteria plan. I have not been and will not be reimbursed for these expenses from any other source, including but not limited to, an insurance plan, this plan, or other programs that may be offered by my or my spouse's employer. I understand these expenses may no longer be claimed as deductions for income tax purposes, since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge that I am solely liable for any taxes or penalties on ineligible expenses submitted through the dependent care account. I am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses and, if applicable, reaffirm the authorization provided to Cobra Professionals, Inc. to issue reimbursement via direct deposit to my bank account on file.

Participant Signature: _____ ***Date:*** _____

Completed claim forms and copies of receipts may be faxed to (225) 706-0280 or scanned and emailed to cpisupport@mycpiteam.com. Please retain originals for your records.