



NORTHWESTERN UNIVERSITY

Flexible Spending Account (FSA) Request for Dependent Care Reimbursement

Calendar Year 2006

Deadline for Submitting Claims
End of February 2007

Instructions: Please type or print the required information. Attach the appropriate receipts, invoices or other documents indicating name of the provider, provider's social security number or Federal Tax I.D. number (FEIN) and amount. You may be reimbursed only for expenses associated with services incurred in calendar year 2005 and only up to your account balance at the time the reimbursement request is processed, Cancelled checks will not be accepted in lieu of an itemized bill or receipt. \$20 minimum. Please sign and return this form to the Department of Human Resources, Benefits Division, 720 University Place, Evanston Campus.

1	Last	First	M.I.	EMPLOYEE ID _ _ _ _ _
	Department		Email Address	Campus Phone

2 WORK-RELATED DEPENDENT CARE REIMBURSEMENT INFORMATION

	Date of Expense From — To	Provider of Services	Provider's Social Security or Tax I.D. Number	Name of Dependent(s)	Eligible Amount*
1					\$
2					\$
3					\$
4					\$
5					\$
TOTAL					\$

* This amount must be filled in before your form will be processed by the Benefits Division. See Instructions on reverse.

3 CERTIFICATION: Please staple invoices including date(s) of service or have dependent care provider sign here. I provided dependent care services for the above named individual. I certify that the information provided above is correct.

Signature of Service Provider Date

4 I request payment from my FSA Dependent Care account for the expenses itemized above. I certify that (1) I have not been reimbursed under this Plan or from any other source for these expenses; (2) I have met all of the requirements for eligible dependent care expenses as described in the FSA Plan materials; (3) the services claimed above were received during the current calendar year and while I was actively making contributions to the Plan; and (4) the total dependent care expenses (if any) for which I am requesting reimbursement this Plan Year do not exceed the lesser of my or my spouse's earned income for the year. I understand that reimbursed expenses cannot be claimed as deductions on my personal income tax return. I understand that according to IRS rules, any account balances at calendar year end will be forfeited.

Claims for Calendar Year 2006 must be received by the Benefits Division or by the Chicago HR Office by the end of February, 2007. Any Remaining Funds in Your Account as of March 1, 2007 are Forfeited Participants Must Re-Enroll to Continue FSA Plan Participation for the Next Year

Employee's Signature Date

FOR OFFICE USE ONLY

Approval: Claim approved: Yes No
Claim not approved:- Reason _____
Claim returned to employee on: _____
Processing: Claim entered into HRIS
 Maximum reached _____

Initials	Date	Claim Number
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NORTHWESTERN UNIVERSITY
Instructions for Completing Your FSA
Dependent Care Reimbursement Form

PERSONAL INFORMATION

1 Please fill out your full name, social security number, department, email (if available) and campus phone number. It is important that we have some means of contacting you via phone or email in case we need to discuss issues pertaining to your claim for reimbursement.

WORK-RELATED DEPENDENT CARE REIMBURSEMENT INFORMATION

2 *Date of Expense:* Please provide the dates from which the service was provided. Billing dates do not qualify as service dates. These dates must indicate the time in which the service was rendered.

Provider of Services: Please provide the name of the company or the name of the individual who has provided the dependent care service.

Provider's Social Security or Tax I.D. Number: Provide either the Tax I.D. number of the service provider or an individual's social security number. In case of au pairs who do not have a social security number, please provide their passport VISA number or a temporary social security number.

Name of Dependent(s): List the names of the dependents for whom the service was rendered. Please note the conditions under which a dependent is considered to be eligible for dependent care reimbursement in the FSA plan document available from the Benefits Division.

Eligible Amount: Please indicate the amount of the expense which is eligible for reimbursement. For example, if you paid \$1000 for your dependent care service and received no funds from any other source to help you pay for the expense, then the entire amount, \$1000, is eligible for reimbursement. Even if there are not available funds in your account to pay the entire \$1000, the claim will roll over to the next month and continue to pay out until it is completely reimbursed. Dependent Care Account participants, (in contrast with Health Care Account participants,) may be reimbursed only up to the amount in the account at the time the reimbursement request is processed. It is imperative that you carefully consider the amount you wish reimbursed to you. The Benefits Division will reimburse only the amount indicated on your form with proper documentation (see certification.) The minimum reimbursement which can be received is \$20.00.

CERTIFICATION

3 You must furnish copies of receipts which prove that you have paid the eligible amounts, to the providers, for which you are claiming reimbursement. If you are not providing an official invoice or statement of payment from your provider, we must have a receipt which shows an amount paid, and the signature of the provider. Receipts include the following:

- Signed receipts
- Canceled checks (front and back), or
- the provider may sign this claim form in section three, and then this claim acts as your receipt. **We must have the provider's Tax I.D. number or social security number to process the claim in this event.**

SIGNATURE

4 Please sign and date your form. Forms which are not signed will be returned to the employee.

All claims received in the Benefits Division by the 15th of the month are eligible to be paid by the end of that same month. Any claims received after the 15th of the month will be processed in the order they are received, however we do not guarantee payment by the end of the same month. If you are using campus mail, please leave some time for delivery especially from the Chicago campus. Please consult the FSA Plan document, available from the Benefits Division, for the detailed provisions governing the Plan. Please staple your receipts to your form(s) so they do not become separated. Mail your completed claims and attached receipts to:

Benefits Division
720 University Place
2nd flr
Evanston IL 60208