Dependent Care Expense Reimbursement Claim Form

Phone: (509) 534-0600
Toll Free: (800) 872-8979
Submit Claims via: **Email:** incent@rehnonline.com
Fax: (509) 535-7883

PARTICIPANT INFORMATION *(Claim may be denied if information is incomplete or not legible)*

Employer Name | **Last 4 Digits of Participant SSN**

First Name | **Last Name** | **Date of Birth** *(mm/dd/yyyy)*

Mailing Address ☐Check here if new | **City** | **State** | **Zip**

Email Address *(home or personal recommended)* ☐Check here if new | ( ) - **Phone Number**

DEPENDENT CARE REIMBURSEMENT INFORMATION

(Electronic submission of your claim can be done securely at INCENT.rehnonline.com)

Dependent Name & Date of Birth	Coverage Period *(mm/dd/yyyy)* Start	Coverage Period *(mm/dd/yyyy)* End	Provider Name, Address & Tax ID Number or SSN	Amount

Total Dependent Care Expense Reimbursement Request **$**

Attach a detailed itemized statement from your provider or have your provider sign this form.

Provider Signature

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more. No payment may be made under the Plan if the service provider is your child, stepchild or dependent for federal income tax purposes who is **under** age 19.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed, by submission of this form, were provided during a period while the undersigned was covered under the Company's Flexible Benefit Plan with respect to such expenses and that the expenses have not been reimbursed prior and that the undersigned will not seek reimbursement under any other coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned. Unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State, or City income tax on amounts paid from the Plan which relate to such expense.

Participant Signature | Date

Dependent Care Expense Reimbursement Claim Filing Instructions

Please keep all original documents for your records!!

When submitting a claim, you can either:

1. Have your provider sign the front of this form under "Provider Signature"

   ~ OR ~

2. Submit an itemized statement from your provider showing the following information:
   a. Time period
   b. Child's Name
   c. Provider Name
   d. Dollar Amount (finance charges are not eligible)

Cancelled checks, credit card slips, balance forward statements or bank statements are **NOT ACCEPTED.**

Submit your claim(s) to Rehn & Associates via:

- **Email:** INCENT@rehnonline.com
- **Fax:** (509) 535-7883. Please number each page (i.e. page 2 of 3, page 3 of 3, etc.)
- **Mail:** Incent Plan, PO Box 5433, Spokane, WA 99205

Please visit www.INCENT.rehnonline.com to:

- View your account balance
- Complete and submit a claim electronically
- Review claims history
- Update your personal account information
- And much more!