

**DEPENDENT CARE
ASSISTANCE PROGRAM
REGISTRATION STATEMENT**



Send completed Voucher to:
M.A. Services Claims Center
PO Box 587
Pittsford, NY 14534
FAX: 585.248-2488

Please read prior to completing the Registration Statement:

- ✓ A qualifying dependent for the Dependent Care Assistance Plan is a dependent child under the age of 13 or a spouse or other dependent adult who's not able to care for himself or herself.
- ✓ In order to qualify the care must be necessary to enable you and your spouse to work, look for work (as long as you found a job and have earned income), attend school full-time or your spouse is physically or mentally incapable of self-care.
- ✓ The payments for care cannot be paid to someone you can claim as your dependent on your return or to a child who is under age 19.
- ✓ You must be able to claim the child as an exemption on your tax return. For an exception see Section 152(e) of the Internal Revenue Code concerning dependents of divorced or separated parents or parents who live apart.
- ✓ Valid expenses include child care, nursery school, before- and after-school care, adult care and in-home dependent care. Tuition for Kindergarten and higher is not a valid expense.
- ✓ Internal Revenue Code Section 129 limits the maximum election amount to \$5,000 (\$2,500 for married filing separately) OR the employee's earned income (if less than \$5,000/\$2,500) OR the spouse's earned income (if less than \$5,000/\$2,500)

Please note that claims will not be paid without a Dependent Care Registration Statement on file. A new form must be completed each year. All sections **MUST** be completed.

EMPLOYEE INFORMATION (Please Print)

Employer:													
Employee Name:		Employee SSN:											
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>											
Address:	City:	State:	Zip:										
Email Address:		Marital Status:											
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced											

SPOUSE INFORMATION (Please Print)

Spouse's Name:	
Spouse's Employer:	Spouse's Annual Wage:
	\$ _____
If Spouse is not employed:	
Is Spouse incapacitated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Spouse a full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete the following)
Name of Institution:	Months of Attendance:

DEPENDENTS (Please Print)

Name	Relationship to Employee	Age

Do you have custody **AND** pay the day care expenses for the above-named dependent(s)? Yes No

If you are claiming coverage under the program for your spouse and other tax dependent over the age of 13, is that person physically or mentally incapable of caring for himself or herself? Yes No

In reference to the above questions, does the **qualifying dependent** spend at least eight (8) hours a day in the employee's household? Yes No

If you have any questions regarding this form or your account please contact us at:
800.836.8100 or info@flexbene.com

SERVICE PROVIDER INFORMATION (Please Print)

Name of Service Provider:

Address:

City:

State:

Zip:

Tax Identification Number / Social Security Number:

Relationship to Employee:

Nature of Services:

Place Where Services will be Performed:

If services are being provided at a day care center (i.e., a facility that provides for more than six (6) individuals not residing at the center), does the day care center comply with all applicable state laws and regulations?

 Yes NoIf service is being performed by one of your children, how old is the Child?
(Children under the age of 19, even if not your dependent, are not eligible service providers.)

Age

Annual Cost of Services:

\$ _____

I certify that the foregoing information is correct and true to the best of my knowledge. I agree to inform M.A. Services immediately of any change in the foregoing information.

Employee Signature: _____

Date: _____