take care®
by WageWorks

DEPENDENT CARE ACCOUNT
PAY ME BACK CLAIM FORM

TOLL-FREE FAX: 877-782-8889
E-mail: claims@takecareclaims.com
Or mail to take care by WageWorks, PO Box 14054, Lexington, KY 40512

To ensure speedy processing:
DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Last Name | First Name

Social Security Number | Employer / Program Sponsor's Name

Zip Code | Birth Month/Day (MM/DD) | E-mail Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

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 dependent care expenses have not been reimbursed or are not reimbursable under any other plan 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, and that 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.

Employee's Signature | Date

DEPENDENT CARE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered From	To	Name, Address and Taxpayer Identification Number of Service Provider	Amount Incurred
Attach a receipt from your daycare provider, or include the daycare provider's signature.			*Provider's Signature:*	
			Total Dependent Care Expense Claim*	0.00

NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Play Year of 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 your dependent for federal income tax purposes who is under 19 years of age.

To complete an electronic claim form or check your account balance go to **takecareWageWorks.com**