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U.A. Local No. 393 Benefit Funds

HEALTH & WELFARE, SUB, DEFINED BENEFIT PENSION AND DEFINED CONTRIBUTION

6293 San Ignacio Ave ▪ San Jose, CA 95119 ▪ P.O. Box 2460 ▪ San Jose, CA 95109-2460
(408) 588-3751 ▪ (408) 436-8210 fax ▪ Staff@ualocal393benefits.org ▪ www.ualocal393benefits.org

Dependent Care Assistance Flexible Spending Account Plan
Reimbursement Request Form

(Please see the reverse side for instructions in preparing and submitting this form)

Participant's Name (Last, First, M.I.)	Social Security Number
Address (Street, City, State, Zip)	Daytime Telephone

List expenses submitted for reimbursement (Please attach all supporting documentation).

Dependent Name(s)		
Relationship to Participant (see instructions on back) ☐ **Spouse** ☐ **Qualifying Child** ☐ **Qualifying Relative** ☐ **Other** ______________		
Type of Service ☐ **Child Care** ☐ **Preschool** ☐ **Before/After School** ☐ **Senior Day Care** ☐ **Au pair** ☐ **Summer Day Camp** ☐ **Other** ______________		
Date of Service FROM: TO:	Dependent Care Provider Name	Reimbursement Amount $

Dependent Name(s)		
Relationship to Participant (see instructions on back) ☐ **Spouse** ☐ **Qualifying Child** ☐ **Qualifying Relative** ☐ **Other** ______________		
Type of Service ☐ **Child Care** ☐ **Preschool** ☐ **Before/After School** ☐ **Senior Day Care** ☐ **Au pair** ☐ **Summer Day Camp** ☐ **Other** ______________		
Date of Service FROM: TO:	Dependent Care Provider Name	Reimbursement Amount $

Dependent Name(s)		
Relationship to Participant (see instructions on back) ☐ **Spouse** ☐ **Qualifying Child** ☐ **Qualifying Relative** ☐ **Other** ______________		
Type of Service ☐ **Child Care** ☐ **Preschool** ☐ **Before/After School** ☐ **Senior Day Care** ☐ **Au pair** ☐ **Summer Day Camp** ☐ **Other** ______________		
Date of Service FROM: TO:	Dependent Care Provider Name	Reimbursement Amount $

More expenses? Please complete another form. **TOTAL Reimbursement Request: $**____________________

The Internal Revenue Code permits dependent care reimbursements only for tax-deductible expenses. The Trustees of the U.A. Local No. 393 Health and Welfare Plan ("the Plan") and/or the Plan is not liable to the participant or any other entity for taxes, interest, penalties or other consequences, which may be assessed by any taxing authority for disallowed expenses.

I request reimbursement for the attached expenses under the U.A. Local No. 393 Dependent Care Assistance Flexible Spending Account Plan. I certify that I or my eligible dependents have received these services and that they are reimbursable under the terms of my employer's Dependent Care Reimbursement program. Furthermore, I certify that the information on this form is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and I certify that I have not been nor will be reimbursed for these expenses from any other source.

______________________________________ ____________________
Participant's Signature Date

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INSTRUCTIONS

1. The expense must be a dependent care expense received by you for care of a qualified dependent as defined by the Internal Revenue code and this Plan.

   - Spouse: include proof of incapacity;
   - Qualifying Child: under age 13. If over age 13, include proof of incapacity;
   - Qualifying Relative: include proof of incapacity and tax dependent status.

2. The expense must be an expense that would have qualified for a tax deduction under the Internal Revenue Code.

3. **Supporting documentation must accompany this request form.** Supporting documentation is defined as a receipt for service showing dates of service, provider's name, dependent's name and amount for the service. **PLEASE NOTE: Balance forward statements and checks (copies of initial and/or canceled checks) are not acceptable.**

4. Complete and sign the Dependent Care Reimbursement Request Form, and submit along with copies of supporting documentation to:

   U.A. Local No. 393 Benefit Funds
   P.O. Box 90640
   San Jose, CA 95109

   Or

   Fax to: (408) 436-8210

   Retain copies of the Reimbursement Request Form and supporting documents for your records, as those submitted cannot be returned.

5. Reimbursements will be made by check.

6. Reimbursements cannot be made for amounts exceeding the balance in your Dependent Care Assistance Flexible Spending Account Plan at the time the request is received.

7. Dependent Care Assistance Flexible Spending Account Plan funds are payable to you and may not be assigned to another person.

8. If you have any questions, call the Fund Office at (408) 588-3751.