

Dependent Care Spending Account Placeholder Claim Form (Payment Card Only)

SECTION A - EMPLOYEE INFORMATION

Name _____
(Print or type: Last, First, Middle Initial)

Mailing Address _____

City, State, Zip _____

Daytime Phone # (_____) _____

Email Address _____

Number of pages faxed

WageWorks, formerly Creative Benefits
PO Box 1928, Vista, CA 92085-1928
FAX: Toll free (888) 295-5757 or (760) 758-4610
EMAIL: claims.vista@wageworks.com
PHONE: Toll free (888) 295-5656

Claim forms and supporting documentation received prior to 2:00 p.m. Pacific Time, are processed the same day.

If you have an address change, be sure to update your records with your employer.

Is this a new address? (check one) YES NO

Social Security # _____
or your Participant ID # _____
as assigned by WageWorks, formerly Creative Benefits

Employer _____

SECTION B - INSTRUCTIONS FOR PLACEHOLDER CLAIM

In order to begin the reimbursement process for using your payment card on your Dependent Care Spending Account, you will need to submit this completed form as a "placeholder" claim along with supporting documentation. Once services have been fully rendered based upon the dates of services and based upon your payroll deductions, your available balance will be loaded onto the card for use.

Please send photocopies of forms and documents. Keep originals for your records, as claim and supporting documentation become part of this claim record and cannot be returned to you. **The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, credit card receipts or statements are not acceptable documentation of expenses.** Receipt of faxed forms cannot be verified due to our large volume. Please call the automated system at (888) 295-5656 after 5:00 p.m. Pacific Time or go online to www.creativebenefits.com to determine if your form has been received and processed.

SECTION C - PLACEHOLDER EXPENSE INFORMATION

| expense description | person for whom expenses were incurred | relationship (child or tax dependent) | date of birth format dates: mm/dd/yy | dates of service (from-to) format dates: mm/dd/yy | paid to provider on a weekly or monthly basis | amount of placeholder |
|---------------------|--|---------------------------------------|--|---|---|--------------------------|
| Placeholder-DC | | | | | | \$ |
| Placeholder-DC | | | | | | \$ |
| Placeholder-DC | | | | | | \$ |

Total amount of placeholder \$

Day Care Provider's Signature: _____ The day care provider's signature can be substituted for the supporting documentation. Name, address and Tax ID# will be required on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Provider's Signature: _____ **Date:** _____

SECTION D - EMPLOYEE CERTIFICATION

- I certify that:
- I have not been reimbursed and will not seek reimbursement for these same incurred expenses under any other plan. I certify that I cannot claim these same expenses for an income tax deduction. All of these incurred expenses qualify as eligible expenses for myself and/or my eligible dependents in accordance with the Plan and IRS Regulations.
 - By providing my email address, I am requesting all communications regarding my account be sent to me via email.

SIGN AND DATE

I certify this claim in accordance with Section D - Employee Certification. Unsigned claims will automatically be denied.

Participant Signature: _____ **Date:** _____

Note: Each year you have a new election for the Dependent Care Spending Account and wish to use the payment card, you will need to submit a payment card placeholder claim to begin the process for the new plan year.