

DEPCARE REIMBURSEMENT REQUEST
UCRS 155 (R1/00) University of California Human Resources and Benefits

Send form and receipts to:
UC HR/Benefits Refunds Unit
P.O. Box 24570
Oakland, CA 94623-1570

For complete information on eligibility, effective dates, maximum contribution amounts, and allowable actions, see the *DepCare Summary Plan Description* and *DepCare Reimbursement Factsheet*, available in your department, from your Benefits Office, or through the UCbencom website: www.ucop.edu/bencom.

To request DepCare reimbursement, submit this form along with **copies** of your receipts. **Receipts must show the dependent care provider's name, the amount of the expense, and the date(s) when the expenses were incurred. See the back of this form for an example of an acceptable receipt.** Do not use cancelled checks in place of receipts.

Do not send original receipts as UC HR/Benefits will not return them.

You will be reimbursed **only** for expenses incurred while enrolled in the plan. You will not be reimbursed for expenses until **after** the care is provided.

Reimbursement cannot exceed your account balance. If you request more than your account balance, you must resubmit a claim for the unreimbursed portion when funds are available. **Submit claims for different calendar years separately.** UC HR/Benefits must receive claims for the prior year by April 15. Only the DepCare participant can submit claims. Claims submitted by other family members or incomplete/unsigned forms will be returned to you. Allow three to five weeks for processing.

Please photocopy this form for your records and send the signed original to UC HR/Benefits. Faxed claims will not be accepted.

PERSONAL INFORMATION		
NAME (Last, First, Middle Initial)	SOCIAL SECURITY NO.	CAMPUS/LAB
CHECK MAILING ADDRESS (Number, Street)	HOME PHONE ()	
(City, State, ZIP)	WORK PHONE ()	

DEPENDENTS				
DEPENDENT NAME	RELATIONSHIP	GRADE IN SCHOOL	BIRTHDATE	<input type="checkbox"/> CHECK IF DISABLED AND OVER AGE 12
DEPENDENT NAME	RELATIONSHIP	GRADE IN SCHOOL	BIRTHDATE	<input type="checkbox"/> CHECK IF DISABLED AND OVER AGE 12
DEPENDENT NAME	RELATIONSHIP	GRADE IN SCHOOL	BIRTHDATE	<input type="checkbox"/> CHECK IF DISABLED AND OVER AGE 12

DEPENDENT CARE INFORMATION					
DEPENDENT CARE PROVIDER	TAXPAYER ID NO. (OPTIONAL)	DATES OF SERVICE (FROM-TO)	AMOUNT OF INCURRED EXPENSES (as shown on receipt)	AMOUNT TO BE REIMBURSED	UNREIMBURSED BALANCE OF ELIGIBLE EXPENSES
1. NAME			\$	\$	\$
NUMBER, STREET					
CITY, STATE, ZIP					
2. NAME			\$	\$	\$
NUMBER, STREET					
CITY, STATE, ZIP					
3. NAME			\$	\$	\$
NUMBER, STREET					
CITY, STATE, ZIP					
TOTAL AMOUNT TO BE REIMBURSED ▶					

EMPLOYEE'S SIGNATURE	
I certify that: 1) I have read the <i>DepCare Summary Plan Description</i> and the <i>DepCare Reimbursement Factsheet</i> ; 2) I have incurred these expenses and have not previously requested payment for them from any source; 3) I have met all the requirements for eligible dependent care expenses (and that all expenses are eligible according to the Internal Revenue Code); 4) I understand that expenses reimbursed under DepCare cannot be claimed as a credit on my income tax return and are directly offset against my income tax credit; 5) services received were necessary to allow gainful employment, and 6) the primary purpose of the services was for care of my dependent(s), and if there was an educational or medical component to the care, it was incidental to and not separate from the dependent care.	
SIGNATURE (must be an original; not a photocopy)	DATE

RETN: UC HR/Benefits: until action taken
Other copies: until action taken

SEE REVERSE FOR PRIVACY NOTIFICATIONS

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves. (B)

The principal purpose for requesting the information on this form is for payment of earnings and for miscellaneous payroll and personnel matters such as, but not limited to, withholding taxes, benefits administration, and changes in title and pay status. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory—failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be used by various University departments for payroll and personnel administration, and will be transmitted to the federal and state governments as required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Associate Vice President—University of California Human Resources and Benefits, 1111 Franklin Street, Oakland, CA 94607-5200.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. Disclosure of the Social Security number is required pursuant to sections 6011 and 6051 of Subtitle F of the Internal Revenue Code and with Regulation 4, Section 404.1256, Code of Federal Regulations under Section 218, Title II of the Social Security Act, as amended. The Social Security number is used to verify your identity. The principal uses of the number shall be to report (1) state and federal income taxes withheld, (2) Social Security contributions, (3) state unemployment and Workers' Compensation earnings, (4) earnings and contributions to participating retirement systems, and (5) as an identifier for your insurance carrier to verify your eligibility and to maintain claim records for you and your eligible family members. (AA)

Sample Provider Receipt

1 KIDS' ADVENTURES
1000 University Way
Berkeley, CA 94720

April 1, 2000

Jane Doe
1344 Maple Lane
Berkeley, CA 94708

For: Michael Doe **2**

Date	Description	Charge	Payments
3/1/00	After-school care (2/1 - 2/28) 4	\$350.00	
3/15/00	Payment (ck. #235)		\$350.00
4/1/00	After-school care (3/1 - 3/31)	\$350.00	
TOTAL DUE			\$350.00

Receipts must include all of the following information or the request for reimbursement will be returned as incomplete:

- 1** The provider's name must be on the receipt. If the provider's name is not preprinted on the receipt, the receipt must include the provider's signature.
- 2** The dependent's name must be on the receipt, especially if you are requesting reimbursement for more than one dependent.
- 3** The amount and description of the expenses should be shown clearly. Eligible and ineligible expenses should be identified.
- 4** Dates of dependent care service should be listed, not just the dates of payment. These dates should agree with those on your claim form.

Note: You may want to keep your provider's Tax ID number or Social Security number for your records.