



## **Dependent Care Reimbursement Fund Application and Q & A**

**\$100 per family per week  
Effective August 2025**

If you are eligible, you may receive reimbursement tax-free to help you pay for the care of a dependent. This packet contains enrollment information that you should read prior to applying for this Fund.

Note: Please be sure to use your Employee ID and Work Address (if work from home please provide your Verizon work address)

Verizon Corp and CWA NYNE/IBEW Local 2213 reserve all rights to alter or modify all eligibility requirements for this "program" or any other "Work and Family reimbursement programs", including but not limited to the amount(s) paid for the reimbursement, eligibility of applicants, proof of payment and all other provisions of this "program" or any other "Work and Family reimbursement programs", including the decision to discontinue this "program" or any other "Work and Family reimbursement program" at any time.

# CWA VERIZON IBEW 2213

## Dependent Care Reimbursement Fund- Enrollment Application

\* Please complete separate application for each child enrolled.

|                                                                                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                 |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Re- enrollment <span style="margin-left: 200px;"><input type="checkbox"/> New-enrollment</span>                                                                                                                                                                                                                                    |                                      |                                                                                                                                                                                                                                                 |                                      |
| <b>Employee Information</b>                                                                                                                                                                                                                                                                                                                                 |                                      |                                                                                                                                                                                                                                                 |                                      |
| EMPLOYEE LAST NAME                                                                                                                                                                                                                                                                                                                                          | FIRST NAME                           | Employee ID: (NOT VZ ID)                                                                                                                                                                                                                        | NCS DATE :                           |
|                                                                                                                                                                                                                                                                                                                                                             |                                      | Job Title                                                                                                                                                                                                                                       |                                      |
| <input type="checkbox"/> CWA LOCAL _____ Local #                                                                                                                                                                                                                                                                                                            |                                      | <input type="checkbox"/> IBEW 2213 <span style="margin-left: 50px;"><input type="checkbox"/> MANAGEMENT</span>                                                                                                                                  |                                      |
| HOME ADDRESS : _____ APT. # : _____                                                                                                                                                                                                                                                                                                                         |                                      | CITY _____ STATE _____ ZIP _____                                                                                                                                                                                                                |                                      |
| HOME TELEPHONE : ( _____ ) _____ area code                                                                                                                                                                                                                                                                                                                  |                                      | PERSONAL CELL NUMBER : ( _____ ) _____ area code                                                                                                                                                                                                |                                      |
| STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED                                                                                                                                                                                                       |                                      |                                                                                                                                                                                                                                                 |                                      |
| PREFERRED E-MAIL ADDRESS ( this will be the e-mail address we will use to communicate with you)                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                 |                                      |
| <b>Work Information</b>                                                                                                                                                                                                                                                                                                                                     |                                      |                                                                                                                                                                                                                                                 |                                      |
| Work address - (if work from home, pls provide VZ address)                                                                                                                                                                                                                                                                                                  |                                      | CITY _____ STATE _____ ZIP _____                                                                                                                                                                                                                | WORK REACH # :                       |
| <b>Dependent Information</b>                                                                                                                                                                                                                                                                                                                                |                                      |                                                                                                                                                                                                                                                 |                                      |
| DEPENDENT FULL NAME                                                                                                                                                                                                                                                                                                                                         |                                      | DEPENDENTS DATE OF BIRTH<br>/ /                                                                                                                                                                                                                 | CURRENT AGE                          |
| IS YOUR DEPENDENT LISTED ON YOUR 2024 IRS 1040 FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                               |                                      |                                                                                                                                                                                                                                                 |                                      |
| <b>In order to be eligible to participate in the fund,<br/>your dependent must reside with you and must be claimed on your income tax.</b>                                                                                                                                                                                                                  |                                      |                                                                                                                                                                                                                                                 |                                      |
| <b>Provider Information</b>                                                                                                                                                                                                                                                                                                                                 |                                      |                                                                                                                                                                                                                                                 |                                      |
| * THIS FORM MUST BE COMPLETED FOR EACH CARE PROVIDER WHEN MULTIPLE PROVIDERS ARE PAID                                                                                                                                                                                                                                                                       |                                      |                                                                                                                                                                                                                                                 |                                      |
| PROVIDER'S FULL NAME or NAME OF CHILD CARE BUSINESS (PLEASE PRINT)                                                                                                                                                                                                                                                                                          |                                      | PROVIDER'S TELEPHONE NUMBER (INCLUDING AREA CODE)<br>( ) -                                                                                                                                                                                      |                                      |
| PROVIDER BUSINESS ADDRESS                                                                                                                                                                                                                                                                                                                                   |                                      | CITY _____                                                                                                                                                                                                                                      | STATE _____ ZIP _____                |
| AMOUNT PAID TO PROVIDER \$ _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> other _____ explain                                                                                                                                                                                 |                                      |                                                                                                                                                                                                                                                 |                                      |
| AUTHORIZED PROVIDERS SIGNATURE :                                                                                                                                                                                                                                                                                                                            |                                      | DATE :                                                                                                                                                                                                                                          |                                      |
| Check all days care is provided.                                                                                                                                                                                                                                                                                                                            |                                      |                                                                                                                                                                                                                                                 |                                      |
| MONDAY<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          | TUESDAY<br><input type="checkbox"/>  | WEDNESDAY<br><input type="checkbox"/>                                                                                                                                                                                                           | THURSDAY<br><input type="checkbox"/> |
| FRIDAY<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          | SATURDAY<br><input type="checkbox"/> | SUNDAY<br><input type="checkbox"/>                                                                                                                                                                                                              |                                      |
| Provider's License Number                                                                                                                                                                                                                                                                                                                                   | Provider's registration number       | Provider's Tax ID                                                                                                                                                                                                                               | Provider's Social Security No:       |
| check all that apply<br><b>FOR CHILDCARE</b><br><input type="checkbox"/> A relative ( non spouse)<br><input type="checkbox"/> Family care provider outside home<br><input type="checkbox"/> Care provided at employees home<br><input type="checkbox"/> Childcare center<br><input type="checkbox"/> Before school<br><input type="checkbox"/> After school |                                      | check all that apply<br><b>FOR ADULT CARE</b><br><input type="checkbox"/> Adult care program<br><input type="checkbox"/> In home services<br><input type="checkbox"/> In home medical services<br><input type="checkbox"/> Other _____<br>_____ |                                      |

# Employee Certification:

I certify that I am: (circle one) Married, Single, Divorced, Legally Separated

- ☐ I certify that the child/children listed as my dependent(s) on this application is/are less than 13 years old and is listed as a dependent on my current Federal Income Tax return. If I am divorced or legally separated I certify the child/children listed as the dependent(s) on this application is less than 13 years old and is in my custody for the greater part of the year.
- ☐ If married and filing separately I certify that the child/children listed as my dependent(s) on this application are listed as dependent(s) on my current Federal Income Tax return. I understand that if my child/children are listed on my spouses 1040 I DO NOT qualify for the Fund under Verizon guidelines
- ☐ Any other dependent listed on this form is physically or mentally incapable of self-care and qualifies as my dependent for Federal Income Tax purposes. The dependent spends at least 8 hours a day in my home.
- ☐ If married, my spouse is employed, or is a full-time student, or is physically or mentally disabled and unable to provide self-care.
- ☐ I certify that my provider is not a relative listed as a dependent on my Federal Income Tax return and not my own child under the age of 19. To the best of my knowledge my provider is in compliance with all the laws and regulations governing the operation of the business.
- ☐ I assume all responsibility for determining the quality and capability of a childcare dependent care provider, and I assume all responsibility for choosing a provider. I understand that Verizon, CWA and IBEW 2213 do not hire, train or supervise child or dependent care providers, nor do they screen, endorse, or recommend any provider of care, nor represent or guarantee the provider I have chosen will provide quality care. I understand Verizon, CWA, and IBEW 2213 are not responsible or liable for any injuries or damages of any nature suffered as result of the acts or omission of a provider of care in the operation of its business.
- ☐ I understand Verizon, CWA and IBEW 2213, retain the right to change the eligibility requirement or amount of reimbursement as well as any other provision of the Dependent Care Reimbursement Fund.
- ☐ I understand that it is my responsibility to notify the Work & Family Committee at 120 Hicksville Road, Room 200-A, Massapequa N.Y. 11758 of any lifestyle change, i.e.: marriage, birth, or adoption of a child. [beverly.steele@Verizon.com](mailto:beverly.steele@Verizon.com)
- ☐ I understand that my eligibility for reimbursement terminates upon my termination of employment with Verizon.
- ☐ I certify to the best of my knowledge, the information I have provided on this form is correct.

Employee Signature /Date: \_\_\_\_\_

While the Regional Work & Family Committee intends to continue the Dependent Care Reimbursement Fund, the NY/NE Regional Work & Family Committee reserves the right to terminate or amend the plan at any time funds are anticipated to be depleted.

# Checklist for Fund Enrollment

Complete this enrollment application and Certification form

You must attach:

- Page 1 of your **2024** IRS 1040 form listing dependents and income
  - you can black out social security numbers
- **2024** W-2 for employee and spouse

Married employees who file separately from their spouse must also attach a copy of their spouse's **2024** IRS 1040 & W-2.

If you or your spouse is self-employed and filed income tax for your business, you must attach a copy of the IRS Schedule C.

If you filed a joint return but are no longer married you must attach legal documentation.

## **Forward via US Mail only:**

- completed application
  - Each child must have their own application form
- certification form
- required tax information
  - Only need 1 set of tax information
  - Remove social security
- copies of any applicable custody/support documents
- If your child is born after you file your taxes, please provide a copy of the birth certificate

NY/NE Regional Work and Family  
Beverly Steele, Fund Administrator  
120 Hicksville Road, Room 200-A  
Massapequa NY 11758  
[beverly.steele@Verizon.com](mailto:beverly.steele@Verizon.com)

In order to receive monthly reimbursement you must first complete an enrollment application and be approved. You will be notified via e-mail regarding your acceptance into the fund. Be sure to provide a valid e-mail address. If no e-mail address is available we will forward your correspondence to the home address you have provided on your application.

Reimbursement begins the month you are approved.

**\* Reminder in order to qualify for reimbursement under the Fund your child/children must be claimed on your 1040 form and payment must be made in your name. \***

# NY/NE Work and Family Committee

## Verizon / CWA / IBEW

|                                                                                                                                                                                                                     |                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Wayne Poole Chairperson<br>CWA Staff Rep<br>Cell: 917-453-0062<br>Email: <a href="mailto:wpool@cwa-union.org">wpool@cwa-union.org</a>                                                                               | Beverly Steele, Fund Administrator<br>120 Hicksville Road, Room 200-A<br>Massapequa NY 11758<br>Email: <a href="mailto:beverly.steele@Verizon.com">beverly.steele@Verizon.com</a>                                               |
| Ana Melo-Papadakis<br>Verizon Labor Relations                                                                                                                                                                       | CWA Local 1101<br>Robert P Shannon, Assistant to the President<br>914-589-3724<br>E-mail: <a href="mailto:shannon61r@gmail.com">shannon61r@gmail.com</a>                                                                        |
| CWA Local 1103<br>Kevin Campo, Business Agent<br>345 Westchester Avenue<br>Port Chester, NY 10573<br>Phone: 914-939-8203<br>Fax: 914-939-5854<br>E-mail: <a href="mailto:KCampo@cwa1103.org">KCampo@cwa1103.org</a> | CWA Local 1104<br>Lindsay Abbate<br>One Florgate Road<br>Farmingdale, NY 11735<br>Phone: 516-420-1104<br>Fax: 516 420-8390<br>Cell: 631-553-0903<br>E-mail: <a href="mailto:macleod712@aol.com">macleod712@aol.com</a>          |
| CWA Local 1106<br>Bill Podmore, Business Agent<br>221-10 Jamaica Ave., Suite 210<br>Queens Village, NY 11428<br>Phone: 917-453-7213<br>E-mail: <a href="mailto:bpod66@yahoo.com">bpod66@yahoo.com</a>               | CWA 1109<br>Roger Young, E-Board Member<br>1845 Utica Ave<br>Brooklyn, NY 11234<br>Phone: 718-444-1109<br>Cell: 917-439-5132<br>Fax: 718-531-1141<br>E-mail: <a href="mailto:ryoung@cwa1109.org">ryoung@cwa1109.org</a>         |
| CWA Local 1118<br>Theresa Devine, Secretary<br>4 Wembley Court<br>Albany, NY 12205<br>Cell: 518-782-9977<br>E-mail: <a href="mailto:theresadevine@me.com">theresadevine@me.com</a>                                  | IBEW 2213<br>Anita Arezzo-Miga Assistant Business Mgr.<br>3000 Troy-Schenectady Rd<br>Schenectady NY 12309<br>Phone: 315-884-4333<br>Office: 315-438-3322<br>E-Mail: <a href="mailto:anita@ibew2213.org">anita@ibew2213.org</a> |

If your local is not listed, please feel free to contact any committee member for assistance.

## **Tax Implications:**

Each employee is responsible for insuring they are in compliance with IRS guidelines. Employees should consult their tax advisor or the IRS ([www.irs.gov](http://www.irs.gov)) about their particular circumstances prior to applying to participate in the DCRF.

- Each household is limited to \$5,000 of tax-free reimbursement per tax year (the limit is \$2,500 if you and your spouse file separate tax returns.)
- The \$5,000 tax-free limit includes the monies from the Fund, and any amount an employee sets aside through the Verizon Dependent Care Spending Account or amounts a spouse sets-aside in any other dependent care account.
- Any reimbursement over the \$5,000 limit will be taxed as income. Any reimbursement in excess of the IRS allowed tax-free level is subject to additional taxation. Since tax situations vary by employee, neither Verizon or the NY/NE Regional Work & Family Committee are responsible for notifying employee or calculating for employees when the reimbursement exceeds the tax-free benefit allowed by the IRS, becoming taxable Income.

## **Dependent Eligibility:**

The Fund is a tax-free benefit and eligible dependents are defined by the Internal Revenue Service (IRS) rules and regulations. See publication 503 Child and Dependent Care Expense [www.irs.gov](http://www.irs.gov).

Your reimbursed dependent care expenses must be for one of the following:

- Your child under 13 years of age that is listed on your IRS 1040 Form as a dependent.
- Your spouse who is physically or mentally unable to care for himself or herself.
- Your dependent that is physically or mentally unable to care for himself or herself.

## **Provider Qualifications:**

- Providers must be licensed or legally operating. If you don't know whether your care provider is legally operating call Spring Health Employee Assistance Program 1 (855) 629-0554 opt 2 or access website <https://benefits.springhealth.com/>
- The Provider cannot be a dependent listed on your IRS 1040 Form.
- The Provider cannot be your child under the age of 18 years or be your dependent child under 19 years of age.
- Please be sure to notify your provider that Verizon will be calling. Your provider should be prepared to verify the amount he/she charges for providing care, hours/days the child/children is in his/her care and his/her license number, registration number, and/or social security number.

# What Is the Dependent Care Reimbursement Fund?

The Dependent Care Reimbursement Fund was established in 1994 as part of the collective bargaining agreement created to help employees pay a portion of their child or elder care expenses.

Licensed care and legal custodial arrangements are major determinants for fund participation. The information provided on your enrollment application will be verified by the NY/NE Regional Work and Family Committee.

The reimbursement is not taxed as long as the amount you receive plus any amount you have set aside in the Dependent Care Spending Account (DCSA), combined with any similar accounts of your spouse does not exceed \$5,000 (\$2,500 if you and your spouse file separate tax forms in the calendar year). Contact the Verizon Benefit Center at 1-855-4VZ-BENS (1-855-489-2367) for more information on the Dependent Care Spending Account (DCSA).

## Who Is Eligible?

- You must be a NY/NE CWA, IBEW 2213, NY/NE Service Company employee or Verizon NY/NE management employee to be eligible to apply to this fund. The Fund is part of the collective bargaining agreement between NY/NE CWA, IBEW 2213 and Verizon. The NY/NE Regional Work and Family Committee oversee the Fund and is comprised of NY/NE CWA, IBEW 2213 and Verizon New York management representatives.
- The Fund rules and eligibility requirements are determined by the NY/NE Regional Work and Family Committee and are in compliance with the Internal Revenue Service.
- Employee application and reimbursed approvals are based on the guidelines established by the NY/NE Regional Work and Family Committee and the Internal Revenue Service.
- The maximum weekly reimbursement amount **\$100** per week per family. Multiple dependents per family are eligible for enrollment. If you are married to a Verizon employee, only one employee may enroll a dependent in the fund.
- You must complete one application for each dependent. All dependent children must be listed on employees 1040 and all payments must be made from accounts in the employees name.
- You may request reimbursement for each day your child is at care. You do not have to deduct your expenses for each day during a short, temporary absence from work, such as for vacation or a minor illness, if you are required to pay for care anyway. An absence of 2 weeks or less is a short temporary absence for the purposes of this fund.
- School tuition to attend kindergarten or a higher grade is not reimbursable.

## Employee Eligibility:

- Active employee.
- You must be in need of dependent care in order to work. Under Federal Law, you and your spouse must be working during the hours your dependents are in care in order to make this a tax-free benefit. The only exceptions are when your spouse is a full-time student, or is physically or mentally incapable of self-care.
- Fund reimbursement cannot be used to pay for child support
- You must report your provider's name, address, and social security or tax identification number on the Enrollment Application, Employee Monthly Reimbursement Form and IRS income tax forms.
  - **Reminder: Re-enrollment including application, W2's and Page 1 of 1040 listing income and dependents must be submitted together with May 2025 reimbursement request post marked no later than 6/13/25 in order to continue in the program.**
- For the purpose of this fund your "provider" must file income tax each year at tax reporting time. Your provider must report all payments he/she receives as a result of this fund.
- You are not eligible to receive reimbursement for any time spent while you are attending college or taking any classes out of your normal working schedule.

## Reimbursement:

Once approved for Fund participation you must submit a monthly request for reimbursement. You must do so by completing a "DCRF Reimbursement Form." The request form must be forwarded monthly and your provider must sign the monthly form each month. Original receipts are to be attached to your completed monthly reimbursement form and mailed it to the fund administrator. Reimbursement generally will appear in the paycheck on the last Thursday of each month for the previous month's expenses.

- In order to be reimbursed a new signed monthly reimbursement form and proof payment in members name must be submitted each month.
- The DCRF Monthly Reimbursement Form must be mailed and postmarked no later than the Second Friday of each month for the previous month's services.
  - Any request for reimbursement mailed after the postmark deadline date will be considered late and will not be paid.
- Employees are responsible for the submission of complete and valid information on all enrollment and monthly forms. Omission of any requested data can lead to non payment.
- Monthly forms should not be faxed unless specifically requested by the Fund Administrator. Xerox copies of application or monthly forms are not accepted unless specifically requested by the Fund administrator.

**Employees must attach a receipt when submitting a reimbursement form.**

**i.e. Receipt from the school / after school provider, Canceled Check or Money Order.**

**\*Receipts from a receipt book are not accepted unless they are stamped by the provider.**



## Appeal Process (Enrollment / Monthly Reimbursement)

- Appeals must be submitted in writing to the NY/NE Regional Work and Family Committee with details of your situation. Enclose all necessary documentation. Your appeal must be received by the committee within 45 days of your written notification of denial of enrollment or within 45 days of non payment of your dependent care expense.
- Submit all appeals to NY/NE Regional Work and Family Committee, % Beverly Steele, 120 Hicksville Road, Room 200-A, Massapequa, NY 11758

## Frequently Asked Questions and Answers

Q: What if I don't have copies of my tax returns and W-2's?

A: Applications will not be considered without supporting tax information. A transcript is not acceptable. Copies of your tax return can be requested from the IRS. Copies of your W-2's can be requested from your employer's payroll department.

Q: What does it mean that I pay for dependent care in order to work?

A: Under federal law, you and your spouse (if applicable) need to be working during the hours your dependents are in care in order to make this benefit tax-free.

Q: If I change dependent enrolled, what is the procedure?

A: Notify the Fund Administrator and complete new application.

Q: I am enrolled and eligible but no longer wish to participate, what should I do?

A: Send written notice to withdraw to: NY/NE Regional Work and Family, Beverly Steele, 120 Hicksville Road, Room 200-A, Massapequa, NY. 11758

Q: My spouse is also a Verizon employee, can we both participate in the Fund?

A: No, if both spouses work for Verizon, the family can only be reimbursed once a month for care. Remember, this also holds true for shared custody and separation. Be sure to send legal documentation to the NY/NE Regional Work and Family Staff.

Q: What is the difference between the Dependent Care Spending Account (DCSA) and the Dependent Care Reimbursement Fund (DCRF)?

A: Under the Dependent Care Spending Account you may reduce your take home pay by setting aside a portion of your income to pay for dependent care expenses. You do not pay taxes on the amount you set aside from your take home pay. Any amount you set aside but do not use for dependent care by the end of the year will not be refunded to you. The total amount that the IRS allows you to set aside tax-free is \$5,000 (\$2,500 if you and your spouse file separate tax forms in a calendar year). Contact the Verizon Benefit Center at 1-855-4VZ-BENS (1-855-489-2367) for more information. The NY/NE Regional Work and Family Committee or Staff does not handle the DCSA.

Q: Can I participate in both the Reimbursement Fund and the Spending Account?

A: Yes. Eligible employees can be reimbursed through the fund AND set aside a portion of their income in the Spending Account and not pay any taxes, up to a combined total of \$5,000. For example, if you anticipate collecting \$2,400 for the next year from the Fund, then you and your spouse would not want to put more than \$2600 in the Dependent Care Spending Account (or similar fund for your spouse) for that year, if you want to

avoid having to pay taxes on amounts over \$5,000. Any amount over the \$5,000 maximum per family per year is subject to taxes. Remember any reimbursement in excess of the IRS allowed tax-free level is subject to additional taxation depending on how you file your taxes. Since tax situations vary by employee, Verizon is not responsible for notifying employees or calculating for employees when the reimbursement exceeds the tax-free benefit allowed by the IRS and becomes taxable income.

Q: When does reimbursement for the care of my 13-year-old end?

A: Reimbursement ends on the last day of the month prior to the month in which he/she turns 13 years old.

Q: If my spouse is disabled or does not work, can I participate in the Fund?

A: Yes, as long as your spouse is physically or mentally incapable of self-care, qualifies as your dependent for federal income tax purposes, and lives in your home. If your spouse is a full-time student, you may participate in the Fund. If your spouse is not working for other reasons, you are not eligible to participate in the Fund. Special rules may apply in these situations and you should speak to your tax advisor regarding your circumstances.

Q: I claim my grandfather as a dependent on my federal income tax return. He lives alone and requires someone to come into his home to provide care. Can I be reimbursed for part of that expense?

A: No, the law provides that your dependent must live in your home in order to be eligible for reimbursement of your care expenses.

Q: My father is in a nursing home, and I help pay for this care. Can I be reimbursed for part of this expense?

A: No, the law provides that out-of-home care cannot be reimbursed.

Q: My mother currently cares for my children in my home while I work. Can I continue this arrangement and participate in the Fund?

A: Yes, as long as:

1. You pay for the care.
2. You do not claim your mother as a dependent on your tax return
3. Your mother is licensed as or legally operating as a child care provider.
4. If not licensed but meets the requirements, the provider must report these monies to the IRS as income.

Q: The enrollment forms ask for personal information. Who will see this information?

A: The information you provide in your enrollment materials will be kept confidential. The only people who see the completed forms will be those directly involved in the administration of the Fund.

Q: If I have dependent care expenses, how do I start receiving money from the subsidy program?

A: A completed enrollment application must be submitted and your participation approved before you may begin to submit monthly claims for reimbursement.

Q: Do I have to re-enroll into the Program each year?

A: Yes. Updated 1040 and W-2's are required by May 30th. If no forms are received you will be suspended from the program until they are. There will be no retroactive payouts for the time you are suspended.

Q: Do I need to submit a receipt in order to receive reimbursement for dependent care expenses if I use a provider which meets legal requirements but is not licensed?

A: Yes, only forms **completed in ink** bearing original signatures will be accepted. Retain copies of your submitted claims for your records.

Q: What if my provider will not give me her social security number or tax identification number?

A: You cannot participate in the Fund unless you provide the dependent care provider's name, address, and social security or tax identification number on the Enrollment Application and Employee Request for Reimbursement Monthly form. If you wish to change providers, the Spring Health Employee Assistance Program will assist you in finding alternative care arrangements. You can reach Spring Health Employee Assistance Program by calling 1 (855) 629-0554 opt 2 or going to their website <https://benefits.springhealth.com/>

Q: How often do I need to complete and submit a Request for Reimbursement Form?

A: The Monthly Reimbursement Form must be postmarked no later than the second Friday of each new month for the prior month expense. Blank claim forms can be reproduced locally. You should keep copies of your dependent care claim receipts for your records.

Q: What if my child/children has/have 2 or more providers in the same claim period?

A: If a dependent has 2 or more providers in the same claim period, a separate Monthly Reimbursement Form must be completed for each provider and submitted to Work and Family Committee.

Q: If I'm not at work because of vacation, scheduled days off, half days or other absence can I still be reimbursed?

A: Yes, you do not have to figure your deductions for each day during a short, temporary absence from work, such as vacation or minor illness, if you have to pay for care anyway. Instead, you can figure your credit including the expenses you paid for the period of absence. An absence of two weeks or less is considered a short, temporary absence for the purpose of this fund only.

Q: How do I know how much I've been reimbursed?

A: For each paycheck that you receive Fund reimbursement, the prior month's amount of reimbursement plus the year to date total will be shown.

Q: Can I claim the child and dependent care tax credit on my personal income tax return if I participation the Fund?

A: No, expenses that are eligible to be used to calculate your tax credit must be reduced by amounts received from the fund and by non-taxable dependent care benefits you and your spouse receive from other sources. Consult your tax advisor for clarification.