Clear Form

Dependent Day Care Provider Acknowledgement

Complete this form to meet the requirements for documenting your day care expenses. This form, once completed, may act as your receipt for expenses incurred.

INSTRUCTIONS

1. **Complete** all sections of this form. Remember to sign and date the bottom of this form.
2. **Ask** your provider to complete Section C of this form.
3. **Submit** this form to Igoe Administrative Services via:
   - Secure Upload through your personal account at www.goigoe.com
   - Email to flex@goigoe.com
   - Fax to 800-456-9083
   - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
4. **Tips**
   - Reimbursements are issued based on your current account balance. Remember that as you make deposits to the account, they become available to you for reimbursement.
   - Services must have already been provided or may be requested up to one month in advance
5. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Dependent Care/Day Care Expenses Incurred

Clear Section B

Dates Covered	Dependent Information Name, Age, Relationship	Description of Expense	Name of Provider	Provider's Tax ID or SSN	Net Amount
-					$
-					$
-					$
-					$
-					$
				Total Dependent Care	**$** 0.00

Section C: Provider Acknowledgement *REQUIRED

(To be completed by the Dependent Day Care Provider)

I hereby acknowledge that the above listed services were provided in compliance with any applicable federal, state and local regulations governing dependent day care centers. I further acknowledge that the dates covered, dependent information, description of the expense, name of the provider, and provider's Tax ID or SSN as listed above are correct.

Provider's Signature: Ready To Sign? Click To Print ***Date:*** _____

Section D: Authorization *REQUIRED

As a participant in the Plan, I certify that all above expenses were incurred during the Plan Year while I was covered under the Flexible Benefit Plan and that the expenses have not been or are not being reimbursed under any other benefit plan. I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to this request. I further acknowledge that each expense for which payment or reimbursement is requested must be a proper expense under the Plan. If not, I understand that I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSMENT IS MADE. Having agreed to all of the proceeding statements, I authorize the Flexible Benefit Plan Account/s in my name to be reduced by the eligible amount requested and reimbursed to me according to my employer's reimbursement schedule and method."

Employee Signature: Ready To Sign? Click To Print ***Date:*** _____

IGOE ADMINISTRATIVE SERVICES