



Yearly Automatic Dependent Care Reimbursement Affidavit

- 1) Have your day care provider **sign** this form in box II. **REQUIRED**
- 2) **Attach** a bill or statement that notes the name and address of provider. **REQUIRED**
- 3) **List** dates of service of the recurring expense (example – Jan 1, 20__ to Dec 31, 20____). **REQUIRED**
- 4) **COMPLETE A NEW FORM EACH NEW PLAN YEAR.**

I. Employee Information

| | |
|---------------------------|---|
| Your Employer | Your Name |
| Day time telephone number | Social Security Number (or Employee ID if applicable) |

II. Certification from Dependent Care Provider – this box must be complete

I, the Dependent Care Provider listed below, certify that I will provide the services as listed below.

Signature: _____ Date: _____

Provider Tax ID # or Social Security # _____

The cost for dependent care service charged to me is as noted below: **Choose one.**

Weekly - Amount paid per week: \$_____ Number of weeks _____ Total: \$_____

Monthly - Amount paid per month: \$_____ Number of months _____ Total: \$_____

Quarterly - Amount paid per quarter: \$_____ Number of quarters _____ Total: \$_____

Yearly - Amount paid per year: \$_____ Total: \$_____

The date of service will begin on _____ and end on _____ (enter a complete date in each section.)

EXAMPLE: \$100.00 per week for 48 weeks = \$4,800.00

I understand that I can only be reimbursed for services with funds that have been posted to my Dependent Care Account and that reimbursements will be made payable to me with a check or direct deposit. I understand that I am responsible to pay my daycare provider.

I understand it is my responsibility to notify ABS if my daycare situation changes (example- a change in dependent care provider or a change in election amount). My employer is responsible for reporting the amount withheld from my pay for dependent care expenses on my year-end W-2. I understand that I must disclose this amount to the IRS when filing my annual tax return. If I fail to provide accurate information, I understand I may be subject to penalties in the event of an audit by the IRS.

IV. Certification

I certify that the above reimbursement submission is for expenses incurred for my eligible dependent.

Signature: _____

Date: _____

How to Submit Affidavit form:

- ABS Consumer Portal or Mobile App (www.abs125.com)
- Email: claims@abs125.com
- Fax: 860-673-2207
- Mail : 30 Mill Street, Unionville, CT 06085

Call: 860-675-2261 • Toll Free: 877-0-673-2207