Dependent Day Care Flexible Spending Account Reimbursement Request Form - DC

(See instructions on reverse side)

A. EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NUMBER *(Required)*	EMPLOYER NAME *(Required)*	ACCOUNT NUMBER(S)
	Boyd Gaming/PERCS	3328095

LAST NAME	FIRST NAME

ADDRESS	CITY	STATE	ZIP/POSTAL CODE

B. DEPENDENT DAY CARE EXPENSES

IF DAY CARE IS PROVIDED BY ONE OF YOUR CHILDREN, PLEASE PROVIDE THAT CHILD'S AGE: ______________

DEPENDENT NAME	DEPENDENT BIRTH DATE	DEPENDENT AGE	PROVIDER NAME AND ADDRESS *(i.e., Day Care Facility Name)*	DATE(S) OF SERVICE	TYPE OF SERVICE

Total Reimbursement Request: $ ____________________

C. CERTIFICATION

I certify that the expenses for which I am requesting reimbursement are for dependent day care expenses which qualify for reimbursement under the Internal Revenue Code and are eligible to be excluded from my federal taxable wages (see reverse of this form for a summary of IRC requirements; consult the IRC or your tax advisor for a more detailed explanation of these requirements). I further certify that these expenses have been incurred by me, they have not been previously submitted for reimbursement, and they have not been reimbursed from any other source, nor do I expect them to be. I agree to notify the CIGNA HealthCare Reimbursement Account Unit immediately if any of these expenses are reimbursed from any other source.

EMPLOYEE SIGNATURE *(Required - unsigned Reimbursement Request Forms will not be considered for reimbursement)*	DATE

INSTRUCTIONS

- COMPLETE SECTIONS A, B AND C IN THEIR ENTIRETY - UNSIGNED REIMBURSEMENT REQUEST FORMS WILL NOT BE CONSIDERED FOR REIMBURSEMENT.
- EACH RECEIPT MUST BE INDIVIDUALLY ATTACHED TO ONE BLANK SHEET OF PAPER IF IT DOES NOT FIT THE STANDARD PAPER FORMAT.
- KEEP A COPY OF COMPLETED REIMBURSEMENT REQUEST FORMS AND THE ATTACHED DOCUMENTATION.
- IF YOU HAVE ANY QUESTIONS, PLEASE CALL: 1.800.CIGNA.24 OR THE 800 # PROVIDED ON THE BACK OF YOUR IDENTIFICATION CARD.
- FOR GENERAL INFORMATION/REQUEST FORMS, VISIT OUR WEBSITE: **www.mycigna.com**
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO: **CIGNA HEALTHCARE**
  P.O. BOX 5200
  SCRANTON, PA 18505-5200
- ALL REIMBURSEMENTS ARE PAID TO THE EMPLOYEE.

Expenses will be reimbursed only after the care has been provided, and not when you are formally billed, charged for, or pay for the dependent day care. In addition, the Internal Revenue Code [Sections 129(e) and 21(b)] requires that an expense satisfy **each** of the following requirements to be eligible for reimbursement:

1. The expense must be incurred by you during a period when you have a dependent or spouse who is a "qualifying individual" who is either:
   (a) a dependent under age 13 for whom you are entitled to an income tax deduction; or
   (b) a dependent or spouse, regardless of age, who is incapable of caring for him/herself.
2. The expense must be for household services or for the care of a qualifying individual which you incur to enable you (and, if applicable, your spouse) to be gainfully employed.
3. Expenses incurred for services provided outside your household at a dependent care center must be incurred for either (a) a dependent under age 13 for whom you are entitled to an income tax deduction; or (b) a dependent or spouse, regardless of age, who is incapable of caring for him/herself who regularly spends at least 8 hours each day in your household. "Dependent care center" means any facility which provides care to these individuals and complies with all applicable laws and regulations and which (a) provides care for more than 6 individuals (other than individuals who reside at the facility); and (b) receives a fee, payment or grant for providing services for any of the individuals.

Note: Special rules apply to divorced parents or married individuals living apart [I.R.C. Section 21(e)].

ADDITIONAL INFORMATION

(If applicable, please use this space to provide additional information.)