Merck & Co. Inc.
Flexible Spending Account
Dependent Care Reimbursement

- Complete all applicable sections. Attach a signed receipt from a qualified care provider or have the provider sign this form.
- If your claim submission is for more than four family members, please submit a separate claim form for each additional family member.
- If you have any questions about a Flexible Spending Account claim, call **1-800-541-6711**. Aetna Life Insurance Company's Automated Voice Response Unit (VRU) is also available to provide current account balance and claim payment information. VRU is available Monday through Saturday, from 7:00 a.m. to 12 midnight ET.
- Items for which you are reimbursed cannot be claimed as deductions or credits on your federal income tax returns.
- Send the completed benefits request and documentation to:
  Aetna Life Insurance Company
  P.O. Box 981106
  El Paso, TX 79998-1106
  1-800-541-6711
- Retain copies for your files. Claim information cannot be returned.
- For information regarding your Flexible Spending Account refer to the DCA section of the Merck Benefits Book.
  Intranet: http://humres.merck.com/benefits/docs/spd_medical_2002.pdf
  Internet: http://www.merck.com/benefits/

[Important Note] If you are submitting a claim with a change in your mailing address, you must notify your employer to make the change on your FSA enrollment file to avoid misdirected claim payments.

Please sign this form and either attach a signed receipt from a qualified care provider or have the care provider sign this form.

1. Employer Information

Employer Name	FSA Control Number
Merck & Co. Inc.	655933

2. Employee Information

Social Security Number	Name	Daytime Telephone Number
– –		( )
Address (include zip code) ☐ Check if address is new		Home Telephone Number ( )

3. Dependent Information/ Expenses for Services Provided

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
____________	☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY)
From ____________ Thru ____________ **Total Amount Submitted** $ ________

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
____________	☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY)
From ____________ Thru ____________ **Total Amount Submitted** $ ________

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
____________	☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY)
From ____________ Thru ____________ **Total Amount Submitted** $ ________

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
____________	☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY)
From ____________ Thru ____________ **Total Amount Submitted** $ ________

4. Expenses for Before & After Kindergarten *

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
____________			

Date(s) of Service (MM/DD/YYYY)
From ____________ Thru ____________ **Total Amount Submitted** $ ________

***Services for day care before and after school are eligible for reimbursement when listed separately.**

5. Provider Information

Provider Name	Social Security Number or Tax ID Number of Provider
Relative ☐ Yes ☐ No	
Address of Provider	Telephone Number of Provider ( )

Cancelled checks are not adequate documentation of services provided.

6. Employee/Provider Certification

Employee certifies that I have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account, and I further declare that I have not and will not claim credit for these expenses on my individual income tax returns.

I further certify that I have read and understand the limitations on reimbursement from my Flexible Spending Account for dependent care expenses, described in the Plan's summary description, as it may be amended from time to time, and that I am eligible to receive benefits under this program.

I also certify that the above dependent care expenses are for the care of qualifying individuals and do not include separate charges for food, clothing, education, entertainment, activities, late fees, transportation or overnight care.

Signature of Employee ______________________ Date __________

PROVIDER CERTIFIES that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have actually been provided.

Signature of Provider ______________________ Date __________

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and, in addition, may be subject to discipline by the Employer, up to and including termination of employment.