

FLEXIBLE BENEFIT PLAN SUMMARY PLAN DESCRIPTION

Your employer has established a Flexible Benefit Plan within the meaning of Section 125 of the Internal Revenue Code of 1986. The Flexible Benefit Plan has been established to offer a choice among benefits with the intent that participants will not have to include as taxable income the amount of compensation they have foregone to pay for contributions to eligible benefits offered by your employer. This Summary Plan Description (SPD) describes the benefits, terms, and conditions of the Plan as it applies to employees of your employer on or after their effective date(s) for participation.

This SPD is a summary of the Flexible Benefit Plan and is not meant to interpret, extend or change the Flexible Benefit Plan in any way. We suggest you read the SPD carefully so that you may understand the Flexible Benefit Plan's operation and its benefit to you. However, the provisions of the applicable Plans can be determined more precisely by consulting the plan documents themselves which are available from your benefits administrator. *In the event of any inconsistencies between this SPD and the actual provisions of the Plan(s), the terms of the applicable Plan Document will govern.*

Plan Name: Illinois Institute of Technology Flexible Benefit Plan

Plan Effective Date: June 1, 2006

Plan Year: June 1, 2007 through May 31, 2007

Plan Administrator/Sponsor: Illinois Institute of Technology
3300 South Federal Street
Chicago, IL 60616

Plan Administrator/Sponsor Phone: [1] 312-567-5323

Identification Number (EIN): 36-2170136

Plan Identification Number: 508

Agent for Service of Legal Process: Illinois Institute of Technology
3300 South Federal Street
Chicago, IL 60616

Agent for Service of Legal Process Phone: [1] 312-567-5323

Please retain this information for future reference.

This model summary plan description describes a cafeteria plan under Section 125 of the Internal Revenue Code of 1986 which includes one or more flexible spending account(s) as benefits eligible for selection by participants.

Advice of Legal Counsel should be obtained before using this summary plan description to inform participants of the cafeteria plan.

Summary of Benefits:

Health Care Flexible Spending Account
Dependent Care Flexible Spending Account
Medical Insurance
Dental Insurance

Who can participate in the Flexible Benefit Plan?

A **Full time and part time** employee of the employer regularly performing services at least **23.25** hours per week shall become eligible to participate on the later of:

- a. **First of the month** following **0** days of employment.
- b. The first of the month following the date on which the Benefits Administrator receives your signed Employee Benefit Election Form.

What happens when I elect to contribute to the Pre-Tax Premium portion of the Flexible Benefit Plan?

As a participant in the Flexible Benefit Plan, you can make your required insurance premium contributions on a pre-tax basis, instead of after-tax. To do this, your regular insurance contribution is deducted from your gross income for each payroll period, and your employer pays your insurance premiums. Your new gross income is your income less the pre-tax contributions to the insurance plans.

What happens when I elect to contribute to Flexible Spending Account portion of the Flexible Benefit Plan?

Your employer will establish a Flexible Spending Account on your behalf. The amount that you elect to contribute will be pro-rated and deducted on a pre-tax basis from each paycheck for the upcoming plan year. These deductions will appear as a credit to your Flexible Spending Account. As you incur eligible expenses, you will submit a claim form in order to be reimbursed from your account.

Are there any ways that my election can be modified by my employer in the middle of a plan year if there is a nondiscrimination problem?

The Flexible Benefit Plan is required to meet certain nondiscrimination provisions as outlined by the Internal Revenue Code. Your employer reserves the right to modify the amount of any benefit elections of the shareholders, officers, owners, and other highly compensated employees by the amount necessary to allow the Plan to satisfy these nondiscrimination requirements.

What happens if I terminate employment?

If you terminate employment, you will no longer be eligible to participate in the flexible benefit plan. Typically, your pre-tax contributions will continue through your last regular payroll period. Please contact your benefits administrator for more information regarding pre-tax contributions if your employment terminates.

Termination of participation in the Flexible Benefit Plan will not affect any rights you may have to continue participation in certain health plans. Your benefits administrator will give you information on how to continue coverage under the health plans, if this is appropriate.

Can I change my decision to participate?

The decision to participate will be binding for the full Plan Year. You may change this election only under the following circumstances:

- a. You may change your participation election prior to the beginning of each new Plan Year. The election you make will be binding for the new Plan Year.
- b. You may make a new election for accident or health coverage (including Health Care Flexible Spending Account), group term life coverage and other qualified benefits (including the Dependent Care FSA) **only if** you had a “change in status” **and** the requested election change is consistent with that change in status. The events that constitute a change in status include the following:
 1. Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.
 2. Events that change your number of dependents, including birth, death, adoption, and placement for adoption. (Note: Gaining or losing a dependent who is not a tax dependent—such as a parent, domestic partner, or child of a domestic partner—will not be considered an allowable event for an election change).
 3. Events that change your employment status or the employment status of your spouse or dependents that affect your eligibility for benefits including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in worksite.
 4. Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.
 5. A change in your place of residence, the place of residence of your spouse or dependent that effect eligibility for benefits under the plan.

For accident and health coverage and group term life, the election change is consistent with the status change only if the change in status event affects eligibility for coverage under the benefit plan with respect to which you are requesting an election change.

For other qualified benefits (including the Dependent Care FSA), the election change is consistent with the status change only if it meets one of the following:

1. The change in status event affects eligibility for coverage under the benefit plan with respect to which you are requesting an election change.
2. The change in status event affects eligibility of expenses described in IRC Section 129 with respect to the Dependent Care FSA.

Please note, it is possible to experience a “change in status” event, but not have the change affect your eligibility to participate in benefits. In this case you cannot make a change in your election.

Are there any other events that allow me to change my decision to participate in the cafeteria plan that do not fit the events listed above?

IRS regulations allow participants to make a mid-year election change to Health Care FSAs or Pretax Premiums for certain “Special Events” that are not specifically addressed in the Changes in Status categories. These events are:

Exception for COBRA Qualifying Events. If you, your spouse or dependent gain or lose coverage due to a COBRA qualifying event, you may change your election to pay for the continuation of coverage on a pre-tax basis or to reduce your election for the corresponding loss of coverage.

Judgement, Decree or Order. If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires a change in accident or health coverage for your child or foster child, you may make an election change to add or drop coverage as ordered.

Entitlement to Medicare or Medicaid. If you, your spouse or dependent becomes entitled to Medicare or Medicaid, you may make a prospective election change to cancel or reduce health coverage under the employer’s plan. If you, your spouse or dependent loses coverage to Medicare or Medicaid, you may make a prospective election to commence or increase coverage under the employer’s plan.

HIPAA Special Enrollment Rights. If you gain the right to enroll in the employer’s group health plan or to add coverage for a family member under the special enrollment rights of HIPAA, the participant may revoke an election for coverage during a period of coverage and make a new election.

Are there any rules that apply if the cost or coverage of my benefits change?

If there is an insignificant increase or decrease in the **cost** of a benefit plan, your employer may automatically change your premium election to cover the change in cost. If the cost change is a significant increase, you may be allowed to either make a new election for the higher cost or revoke your election, but you must elect similar coverage if available. If the cost change is a significant decrease, you may be allowed to commence participation for the option with a decrease in cost.

You may be able to change your Dependent Care election if your daycare provider changes the cost of daycare. However, you cannot change your election if the daycare provider who changes the cost of the daycare is a relative or family member.

A plan may also allow an election change if any of the following occurs (this also applies to the spouse or dependent covered under the employer’s plan):

- **Significant Curtailment of Coverage that is not a loss of coverage.** If your coverage is significantly curtailed without a loss of coverage, you may revoke your election under the plan that is being curtailed, but must make a new election for similar coverage under a new benefit package option.
- **Significant Curtailment of Coverage with a loss of coverage.** If your coverage is significantly curtailed with a loss of coverage, you may revoke coverage under the plan being curtailed and make a new election for similar coverage under a new benefit package option, if available.
- **Addition or improvement of benefit package option providing similar coverage.** If during a period of coverage a benefit plan adds a new coverage option or significantly improves a benefit option, you may be allowed to elect the new option or improved benefit option prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage.
- **Coverage change of another employer plan.** You may change your election if the change is on account of and consistent with a change in another employer’s plan and (i) the change is permitted under the cafeteria plan of the other employer or (ii) the periods of coverage under your plan are different from the periods of coverage under the plan of the other employer.

Can I make a new election if I terminate employment and I am rehired in the same plan year?

If you terminate employment and **rehired in less than 30 days**, you will re-enter the plan with the same election you had before you left. The employer must allow the full target amount. In this case, you do not have to pay the missed premiums, but expenses incurred during the time off are not eligible.

If you are rehired **after 30 days**, the employer may allow one of the following three options:

- Continue with the same election
- Make a new election
- Wait until the next plan year to participate

Please see the benefits department for more information on the options that are available to you.

When do changes in election become effective?

If you make a change in election, your new election amount will be effective the latter of:

- a. **First of the month** following date of event
- b. The first of the month following the date on which the Committee receives the Participant's written notice.

If you experience a change in status and would like to change your election, please contact your benefits administrator as soon as possible.

Are there special rules that affect participants in the flexible benefit plan who take a leave under FMLA?

Under the Family and Medical Leave Act (FMLA), you are entitled to continue health coverage during the period of the leave if this benefit was in effect prior to the date on which the leave began. If this is the case and you participate in the flexible benefit plan, you are required to make any applicable contributions to the flexible benefit plan for coverage extended during the leave. If the leave is paid, salary deduction contributions will continue during the length of the leave. If the leave is unpaid, there are several options available for you to continue contributions to the flexible benefit plan during your leave or you have the right to terminate coverage during the leave and reinstate it when you return from leave. Please see your benefits administrator for details.

What happens if I do not incur enough eligible expenses during the plan year to claim reimbursement of all the money I have contributed to the Flexible Benefit Plan?

IRS rules do not permit a refund of any unused funds that remain in your Flexible Spending Account at the end of a plan year. Also, you cannot transfer money designated for the Flexible Spending Account to any other account or fund. For this reason, it is important that you be conservative when setting your targeted contributions.

How much time do I have to submit a claim?

If you remain a participant in the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account for the full plan year, you will have **90** days after the end of the plan year to submit a claim for expenses incurred the previous year. If you terminate participation in the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, your employer may allow one of the following options:

- You will have **90** days after the end of the plan year to submit a claim for expenses incurred during your period of coverage.
- You will have **90** days after your termination date to submit a claim for expenses incurred during your period of coverage

Please see the benefits department for more information on which option is available to you. Remember that funds contributed for one plan year cannot be used to reimburse you for expenses incurred in another plan year.

Are there other ways that my participation in the Flexible Benefit Plan can be terminated?

If you no longer meet the eligibility provisions of the Flexible Benefit Plan or your employer terminates the plan, your participation will be terminated.

Are the benefit contributions to the Flexible Benefit Plan reported as income on my Form W-2?

The amounts that are contributed to the Flexible Benefit Plan are not considered taxable wages by the IRS and most States. As a result, "wages, tips, and other compensation" reported for federal income, state income (except New Jersey and Dependent Care FSA contributions in Pennsylvania), and FICA on your W-2 will be your gross income less any benefit contributions to the Flexible Benefit Plan.

How do Flexible Benefit Plan contributions affect my Social Security benefit?

Participation in the Flexible Benefit Plan reduces your gross taxable income and may affect your Social Security benefit by reducing the total taxable income used to calculate your Social Security benefit. In most instances, the current tax savings under the Flexible Benefit Plan will outweigh the slight impact on future Social Security benefits.

Can my employer terminate or amend the Flexible Benefit Plan?

The Flexible Benefit Plan can be amended or terminated, in whole or in part at any time, by your Employer or its Board of Directors (if applicable) in the same manner as the plan was adopted. Consent of any participant, employee or any other person referenced in the Plan is not required to terminate the Plan except to the extent the right to terminate is limited by a collective bargaining agreement, if any.

How can I appeal a claim decision made under the Flexible Benefit Plan?

If you, as a Participant in the Flexible Benefit Plan, or your beneficiary believe you are entitled to a benefit under the Flexible Benefit Plan that is different from the amount that has been paid, you may file an appeal with the Plan Administrator. You will also be given an opportunity to review any Flexible Benefit Plan documents involved. This appeal must be made in writing within 180 days of the initial determination of the amount that has been paid to you and must contain the following information:

- The reason(s) for making the appeal
- The facts supporting the appeal
- The amount claimed
- The name and address of the person filing the appeal (claimant)

The Plan Administrator will generally make a decision within 60 days after receiving the appeal and must mail a copy of the decision to the claimant promptly. The decision will give specific reasons and references to the Flexible Benefit Plan provisions which support the Plan Administrator's decision.

Pre-Tax Premiums

What happens to my Pre-Tax Premium election if I drop my insurance during the middle of the Plan Year?

The decision to elect to pay your insurance premiums pre-tax through the Flexible Benefit Plan is binding for the full Plan Year, unless you are eligible for a change allowed by the IRS. If you drop your insurance coverage in the middle of the Flexible Benefit Plan Year without an allowable reason (i.e., change in status), you may be required to continue to have the premium amounts deducted from your gross income under the Flexible Benefit Plan.

Can my employer modify my Pre-Tax Premium election under the Flexible Benefit Plan?

If the amount of your required premium contributions(s) increases or decreases insignificantly as a result of a rate adjustment, your employer will automatically increase or decrease the amount of your Pre-Tax Premium elections(s).

Can I change my Pre-Tax Premium election under the Flexible Benefit Plan?

You may change your pre-tax premium election only under the following circumstances:

- a. In coordination with each new plan year
- b. If you experience a change in status (as previously described)
- c. If you experience a special event (as previously described)
- d. If you experience a cost or coverage change (as previously described)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Maximum Plan Year Contribution: \$4,000.00

Minimum Plan Year Contribution: \$0.00

How do I qualify to use the Health Care Flexible Spending Account?

If you incur eligible medical expenses during a plan year (such as out-of-pocket deductibles and co-payments) that are not payable from other sources, you can use the Health Care FSA to reimburse you for these expenses with tax-free contributions.

What are examples of eligible medical expenses that qualify for reimbursement from the Health Care FSA?

Eligible expenses must be allowed as a medical deduction under Internal Revenue Service rules. Sample health care expenses may include deductibles, co-payments, amounts over the maximum your plan pays for hospital rooms, reasonable and customary allowances, and psychiatric care. Other health care charges that may be covered include routine physicals, vision care, hearing care, dental and orthodontic care.

Can I use the Health Care FSA for my family's health care expenses?

Eligible health care expenses incurred by you, your spouse, or any individual who is defined as a dependent for federal income tax purposes are allowable for reimbursement.

What are some examples of expenses not eligible for reimbursement?

Examples of expenses specifically disallowed from this program include: Cosmetic surgery that does not meaningfully promote the proper function of the body or prevent or treat an illness or disease; membership fees or costs of weight loss programs done for your general health; and premiums paid for insurance coverage.

What do I submit to get reimbursed for qualifying medical expenses?

As a participant you will receive a supply of Claim Forms. To be reimbursed for eligible expenses, you simply complete a signed form and return it with the supporting documentation to the address on the form. Upon receipt, review, and approval of the claim, you will be reimbursed from your spending account. Reimbursement for qualifying health care expenses will be made up to the total amount of your plan year contribution, less any previous reimbursements. For reimbursement of expenses partially covered under another health care plan:

- Submit expenses through your primary health care plan (i.e., insurance provider) for processing of covered expenses.
- If you also have coverage through a second health care plan, such as under a spouse's plan, you must also submit claims to this source for processing.
- Once processed by all your health care plan carrier(s), complete the FSA Claim Form and attach a copy of the Explanation of Benefits (EOB) form(s) showing the remaining amount of unpaid expenses
- Send the completed form (and applicable EOBs) to the address on the form.

For reimbursement of expenses not covered under another health care plan:

- Complete and sign the FSA Claim Form
- Attach itemized bills for the eligible medical expenses.
- Send the completed form and itemized bills to the address on the form.

How do I claim reimbursement for orthodontia expenses?

If you pay for the ongoing care of orthodontia, your expenses will be reimbursable if **payment** for current years services is made by you during the current plan year, even if full treatment will not be performed until a future date within that current plan year.

If I contribute to a Health Care FSA, does it affect my ability to take advantage of the IRS Medical Expense Tax Deduction on my personal income tax filing?

Expenses that are reimbursed through the Health Care FSA cannot also be used as deductible expenses when filing your personal income taxes. However, the Health Care FSA allows you to save taxes on health related expenses, even if the expenses do not exceed the 7.5% of your gross income required to claim them as a deduction on your personal income tax return.

Are there any special rules regarding the Health Care FSA if I terminate employment?

If you terminate employment, your participation in the Health Care FSA will automatically terminate. You can receive reimbursement for eligible health care expenses incurred prior to termination. However, if coverage would otherwise end due to a qualifying event as outlined in the COBRA laws, you and your covered spouse and dependents may be able to continue coverage under the Plan on an after tax-basis, depending on the nature of the event. Your benefits administrator will give you information on how to continue coverage under the Health Care FSA, if this is appropriate.

Statement of Rights

As a participant in the Health Care FSA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites and union halls), all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor (such as detailed annual reports and Plan descriptions); obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies. You are also entitled to receive a summary of the Plan's financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report, with certain exceptions.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Health Care Flexible Spending Account. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Maximum Plan Year Contribution: The lesser of:

- **\$5,000 (\$2,500 if married and filing a separate tax return); or**
- Your earned income or your spouse's earned income. If your spouse is a full-time student or is disabled, the spouse is deemed to have an income of \$200 per month for one dependent, or \$400 per month for two or more dependents. Effective after January 1, 2003, these amounts shall be \$250.00 per month for one dependent, \$500.00 per month for two or more dependents.

Minimum Plan Year Contribution: \$0.00

Do I qualify to use the Dependent Care Flexible Spending Account (FSA)?

To be eligible to use the Dependent Care FSA, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You are a single parent
- You have a working spouse
- Your spouse is a full-time student at least five months during the year while you are working
- Your spouse is physically or mentally unable to provide for his/her own care
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes

What is an eligible dependent for the Dependent Care FSA?

An eligible dependent is an individual whose care expenses may be reimbursed under the Dependent Care FSA. The individual must spend at least eight (8) hours per day in your home and can be any one of the following:

- A child under age 13 for whom you have custody most of the time even though your former spouse may claim the child for income tax purposes
- Any other dependent who is physically or mentally unable to care for himself or herself
- Your spouse, if physically or mentally incapable of self-care

What expenses are eligible for reimbursement under the Dependent Care FSA?

For purposes of the Dependent Care FSA, an expense must meet certain plan guidelines to qualify as an eligible expense. To be considered an eligible expense, the service must:

- Be incurred during the current plan year and your period of coverage under the plan
- Be provided for the care of a qualifying dependent or other related household services for the care of that qualifying dependent (includes any payroll taxes paid on wages for a qualifying dependent care provider)
- Be incurred to enable you to work

NOTE: If married, your spouse must also work; be a full-time student at least five months during the year while you are working; or be physically or mentally unable to provide his/her own care in order for the dependent care expense to qualify as an eligible expense.

How much reimbursement will I receive each time I submit a claim?

Your benefits administrator will reimburse the claim up to the available balance in your Dependent Care Flexible Spending Account at the time you submit the claim. If there aren't sufficient funds in your FSA to reimburse the entire claim, the remaining amount of the claim will be paid as soon as there have been enough payroll deductions credited to your account. You will not have to re-submit the claim.

What are some examples of expenses not eligible for reimbursement?

Certain types of expenses are not eligible for reimbursement under the Dependent Care FSA. Examples of ineligible expenses may include:

- Services which are primarily educational or medical in nature. (Pre-school is generally regarded as primarily for the child's well-being and protection and not primarily educational)
- Educational expenses at kindergarten level or higher
- Services provided on behalf of a qualified dependent while the employee (or spouse) is not working
- Household services provided by individuals who are not responsible for providing care to the dependent
- Overnight camp costs

What is a qualifying dependent care provider?

A qualifying dependent care provider is a provider whose services qualify for reimbursement from your Dependent Care Flexible Spending Account. Qualifying providers may include:

- Dependent care centers. If the center provides care for more than six non-resident individuals, it must meet all applicable state and local regulations
- An individual who provides care inside or outside your home. However, a child of yours under age 19 or any other individual for whom you can claim a personal exemption does not qualify as a care provider
- Facilities for pre-school children
- A housekeeper whose services include, in part, providing care for a qualifying dependent

What do I submit to get reimbursed for qualifying dependent care expenses?

As a participant, you will receive a supply of Claim Forms. To be reimbursed for eligible expenses simply complete a signed form and send it with the supporting documentation to the address on the form. Upon receipt, review, and approval of the claim you will be reimbursed from your spending account. When completing a Claim Form, you must include the following information:

- The dates of service
- The amount of the charge
- The name of the providers of the services
- Signature of provider on the claim, or receipt or other proof of payment

If I contribute to a Dependent Care Flexible Spending Account, does it affect my ability to take advantage of the IRS Dependent Care Tax Credit?

Yes. Any reimbursements received through participation in the Dependent Care Assistance FSA are not eligible for the credit and reduce the amount of eligible expenses which can be claimed under the tax credit.

Are there any tax reporting forms which I must file when I contribute to the Dependent Care FSA?

Yes. Although you will not have to pay federal, Social Security and State (except PA and NJ) taxes on amounts you contribute to the Dependent Care FSA, the total will be recorded in a separate box on your Form W-2. When preparing your tax return, you should complete and file an IRS Form 2441 or Schedule 2. Form 2441 or Schedule 2 requires that you report the name, address and taxpayer I.D. number of your dependent care provider(s). These forms are submitted to the IRS to identify dependent care reimbursements received through the Dependent Care FSA and to calculate any expense which may remain eligible for the IRS Dependent Care Tax Credit. You can request the identifying information from your dependent care provider(s) on IRS Form W-10. Form W-10 does not need to be filed with any government agency, but should be retained for your own records.