

DEPENDENT CARE ASSISTANCE PROGRAMS

This is a two-step process. Step 1 documents the pre-authorization process and Step 2 documents final approval.
BOTH PAGES must be provided to the timekeeper when expense reimbursement is requested.

PURPOSE AND ELIGIBILITY

- a) **Purpose:** This form allows you to request reimbursement of pre-authorized, eligible incremental dependent care expenses incurred under one of the four Dependent Care Assistance Programs listed below. Please see the [Relocation Handbook](#) or contact the Relocation office for more information regarding expenses related to Home Selection Trips. This form is not to be used for reimbursement of any employee expense for the *Back-Up Care Advantage Program™*. Additional information on each program can be found on *ExxonMobil Me*.
- b) **Eligibility:** These programs apply to most regular employees on the U.S. dollar payroll. Eligibility for represented employees is governed by local bargaining agreements.
- c) **Eligible Expenses:** Incremental dependent care expenses are allowed if you meet all of the guidelines of the respective programs. Incremental dependent care is care that is in addition to the primary care that you are expected to have arrangements for on an ongoing basis during your workday. Acceptable dependent care expenses include local prevailing rates for care service providers, transportation for a relative to stay with your dependent(s) at your home location, transportation of your dependent(s) to the U.S. residence of a relative. No reimbursements will be made to relatives for dependent care, meals or lodging during this time period.
- d) **Ineligible Expenses:** Routine, ongoing care expenses that enable you to hold your ExxonMobil job. Care that results from routine travel. Care provided by family members. Care provided by friends, neighbors, or others not generally employed as trained dependent care providers, except for overnight care when you prefer someone known to your dependent. Any out-of-pocket expenses (e.g. co-pays) related to employee's use of the *Back-Up Care Advantage Program™*.

[1] EMERGENCY BACK-UP CARE EXPENSE REIMBURSEMENT

- a) ELIGIBILITY REQUIREMENTS (**ALL** REQUIREMENTS MUST BE MET):
 1. **Urgent business need.** The business need on which you are working must be determined by your supervisor to be sufficiently urgent that it cannot be rescheduled to a time when your routine dependent care, or routine back-up care, is available.
 2. **"Last minute".** The breakdown in your routine care occurs, or the business need is identified, at the "last minute," thus limiting your ability to develop other alternatives.
 3. **Non-routine.** The dependent care need is not a routine need that enables you to hold your ExxonMobil job.
 4. **Dependent.** The care is needed for one or more dependents living in your home (i.e., children under 17 who cannot be left alone, or physically or mentally impaired family members of any age who cannot be left alone).
 5. **Advanced supervisory authorization.** Authorization to use the program is obtained from your supervisor in advance.

[2] OVERNIGHT RECOGNITION EVENTS

- a) ELIGIBILITY REQUIREMENTS (**ALL** REQUIREMENTS MUST BE MET):
 1. The recognition event is located in another city and involves an overnight stay.
 2. The purpose of the event is primarily for recognition. This program does not cover events where recognition is a small part of a longer meeting.
 3. You and your spouse attend the event (unless you are a single parent).
 4. DOAG 4 pre-approval is required.
- b) The following are not eligible for reimbursement:
 1. Recognition events in the city of residence.
 2. Overnight recognition events that the spouse does not attend (unless you are a single parent).
 3. Company holiday parties.
 4. Formal recognition events that do not require an overnight stay.
 5. Business meetings at which recognition is only a small part of the overall purpose of the meeting.

[3] FOLLOWING THE DEATH OF A SPOUSE

- a) ELIGIBILITY REQUIREMENTS (**ALL** REQUIREMENTS MUST BE MET):

Supervisors are strongly encouraged to support the need of the employee to be with his/her family during this difficult time by minimizing work hours and deferring travel whenever possible. However, in the event that a trip cannot be cancelled, postponed, or assigned to someone else, management may authorize reimbursement of incremental dependent care expenses in the following circumstances:

 1. Incremental expense is incurred within a temporary transitional period after the death of the spouse (typically 1 to 3 months).
 2. DOAG 6 pre-approval is required.

[4] FOR INFREQUENT TRAVELERS

- a) ELIGIBILITY REQUIREMENTS (**ALL** REQUIREMENTS MUST BE MET):
 1. **Non-routine business need/ time sensitive.** The need to travel is outside the normal scope of the employee's job, and timing is not optional (the employee must make this trip at this time), and
 2. **Non-routine dependent care arrangements.** Situation must be outside normal care arrangements (e.g., nights and weekends, not daycare), and
 3. **Infrequent travel.** Employee's position requires no more than 2 trips per year, and
 4. **Extended.** Eligible expenses for reimbursement begin on the third night of the trip; that is, incremental childcare expenses are not reimbursable for the first two nights of any trip, regardless of trip length
 5. DOAG 6 pre-approval is required.

Note: Travel to attend training is not eligible for reimbursement.

[5] RELOCATION HOME SELECTION TRIPS

Please see the [Relocation Handbook](#) or contact the Relocation department for more information.

STEP 1 PRE-AUTHORIZATION

Circle which of the Dependent Care Assistance Programs (described above) applies: [1] [2] [3] [4]

Employee name _____ Date _____

I certify that this employee meets **all** of the eligibility requirements for the Dependent Care Assistance Program cited above. I pre-authorize this employee to incur incremental dependent care cost as associated with the above program.

Pre-Approver Name _____ DOAG Level _____

For a list of DOAG 4 (required for program 2) or DOAG 6 (required for programs 3 & 4) approvers, [click here](#) to view the Profile section of the DOAG.

Pre-Approver Signature _____ Date Pre-Approved _____

DEPENDENT CARE ASSISTANCE PROGRAMS STEP 2 - APPROVAL OF EXPENSE REIMBURSEMENT

APPROVAL PROCESS

1. Discuss with your supervisor whether or not you meet the eligibility criteria of the applicable Program.
2. Complete Step 1 of this form and submit to your supervisor.
3. Supervisor obtains Step 1 pre-approval and gives original of this form to employee.
4. After expense is incurred, to claim reimbursement, complete Step 2 and submit this form (both pages 1 and 2) and original receipts to your supervisor. Please retain a copy of all documents for your records.
5. Supervisor submits the completed form (both pages 1 and 2) and supporting documentation to your group's timekeeper for entry into the payroll system and for file retention of the form and original receipts. Supervisor's approval indicates that the requested reimbursement is within limits set by local management (based on local work practices and/or prevailing market rates)

FINAL APPROVAL OF PRE-AUTHORIZED DEPENDENT CARE EXPENSES

Employee: Print your name and personnel number, sign, date and present this form along with original itemized receipts from the trained dependent care provider to your supervisor for approval.

Dependent Care Assistance Program _____

<u>Name of Dependent Requiring Care</u>	<u>Age</u>	<u>Name of Provider</u>	<u>Date</u>	<u>Duration of Care</u>	<u>Total Care Cost</u>
_____	_____	_____	_____	Hours _____	\$ _____
_____	_____	_____	_____	Hours _____	\$ _____
_____	_____	_____	_____	Hours _____	\$ _____
Actual Total: Hours					\$ _____

Employee:
Name (print) _____ **Personnel Number** _____
Signature _____ **Date** _____

Supervisor: The amount you authorize to be paid to the employee may be less than the Total Care Cost above due to limits set by local management (based on local work practices and/or prevailing market rates). Please indicate the amount to be paid in the space provided below, print your name and phone number, sign, date and submit this form (with original receipts) to the group's Timekeeper.

Amount Authorized for Reimbursement: \$ _____

Explanation if Amount Authorized for Reimbursement is different from Total Care Cost: _____

Supervisor:
Name (print) _____ **Phone #** _____
Signature _____ **Date** _____

ADDITIONAL INFORMATION

- a) **Tax Treatment:** The reimbursement will be included in your normal paycheck and is considered taxable income that is subject to all applicable payroll taxes. Taxes will be withheld, and the income will be reported in your W-2.
- b) **Effective Date:** Eligible expenses incurred on or after January 1, 2005 are covered.
- c) **Reimbursement Amount:** Actual documented expenses will be reimbursed, up to limits set by your local management. Reimbursement levels will be based on prevailing market rates in your location.

For Payroll Timekeeper Use Only	Both pages 1 and 2 of this form must be submitted. Employee's Payroll Location Code _____ Payroll Period from _____ to _____ Amount Authorized to Pay \$ _____ Earnings Code 3036 Timekeeper: _____ Date _____
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