DEPENDENT CARE ACCOUNT CLAIM FORM

A. ACCOUNT HOLDER INFORMATION -- COMPLETE FOR ALL CLAIMS (PLEASE PRINT CLEARLY)				
Employer Name:			This claim applies to the plan year ending on:	
Employee Name:	Last:	First:	Middle Initial:	
Mailing Address:	Street:	City:	State:	Zip:
Social Security Number or Employee ID:		E-Mail Address:		

In order for a DCA claim to be eligible for reimbursement, there are four pieces of information that must be included on the receipt: Name of provider, dates of care, type of care and the amount due for the dates of care provided on the receipt.

B. DEPENDENT CARE REIMBURSEMENT / DAYCARE EXPENSES **Future Date(s) of Service will not be processed**

Item #	Dependent's Name	Age	Date(s) of Service** From	To	Service Provider (Name & Soc. Sec. No. or Tax-ID)	Amount of Claim
D1						$
D2						$
D3						$
D4						$
D5						$
D6						$
D7						$
					Total Amount	$

IF A RECEIPT OR BILL IS NOT SUPPLIED BY YOUR DEPENDENT CARE PROVIDER, HAVE THEM COMPLETE THE ABOVE SECTION AND SIGN BELOW.
I, the undersigned, am not a dependent of the participant. I have provided day care for the dependents listed above for the periods indicated. The participant has incurred the expense for these services.

x____ ______________________

Dependent Care Provider's Signature (necessary only if receipt is not provided) Date

C. PARTICIPANT'S STATEMENT AND SIGNATURE (PLEASE READ CAREFULLY)

To the best of my knowledge and beliefs, my statements in this Reimbursement Request Form are complete and true. I certify that I or my family member has received the service described above on the dates indicated and that expenses qualify as valid expenses under the Plan and that I have not been previously reimbursed by this or any other plan nor do I expect any of these expenses to be reimbursed elsewhere. A copy or electronic facsimile of this form shall be deemed as valid as the original.

Plan Participant's Signature	Date

Mail, Fax, or Email all requests to:
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Toll-Free Phone: (888) 318-7472 Toll-Free Fax: (877) 723-0146
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