Claim Form – DCAP Reimbursement

☐ *Please check here if new mailing address* ☐ *Please check here if new email address*

Employer Name (Please Print) _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

Dependent Care Claims

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. Use a copy of this form if you need more space. All information below must be completed.

Service Period

From	To	Dependent Name	Age	Provider Name & Address	Provider Tax ID#/SS#	Amount
						$
						$
						$
						$
						$
						$
					Total	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature _____ Date ____ / ____ / ____
mm/dd/yy

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP