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

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