# **Dependent Care Reimbursement Account Claim Form**



(Do not fax or mail this instruction page.)

In general, and subject to the rules of your employer's plan, the following rules apply to dependent care expenses:

- The individual receiving the care must be a child under the age of 13, or another dependent who is physically or mentally incapable of caring for themselves.
- The expenses must be incurred so that: (1) you and your spouse, if married, can work; (2) your spouse can attend school on a full-time basis; or (3) you or your spouse can work, if one of you is disabled.
- Services provided by a child care or elder care center must comply with all state and local laws to be an eligible reimbursement expense.
- You can be reimbursed only for services that have been received.

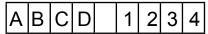
### Option 1: Go Paperless!

You won't need to complete paper forms anymore. Just submit claims online at www.mybenefitwallet.com.

## Option 2: Submit your claim using this form

#### Step 1: Fill out the form

• Please print in capital letters with the letters centered in the boxes as shown:



- · Complete a separate line for each individual expense.
- Use page 4 if you exceed the number of lines available on page 3.

#### **Step 2: Attach Supporting Documentation**

- See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable
  by the IRS.
- Do **not** send original receipts or original supporting documentation.
- Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.

#### Step 3: Certify

Read the Certification and then sign and date the form.

#### Step 4: Submit

- FAX the form and supporting documentation to 877.841.1152.
- Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.
- Alternatively, you may also mail your claims to:

#### **BenefitWallet**

#### P.O. BOX 18009 Suite A

#### Norfolk, VA 23501

To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

#### Remember

Keep a copy of the form and all original receipts for your records.



## **Types of Supporting Documentation**

- Copy of itemized receipts of your dependent care expenses, or signed provider affidavit on the claim form, for each expense.
- All documentation submitted to substantiate a claim must include the following information:
  - Name of the person who incurred the service or expense
  - Name and address of the provider or merchant
  - Tax ID Number or Social Security Number of the care provider
  - Date(s) the service was provided
  - Amount charged for the service or expense
- Cancelled checks or payment statements alone are not acceptable documentation.

#### Please Do

- Include the Provider Tax ID or Social Security Number.
- Have your provider sign the affidavit on the claim form if you do not have receipts.
- Use additional copies of page 4 if your expenses exceed the number of lines available on page 3 and page 4.
- Be sure to print legibly and use capital letters.
- · Use black ink.

#### **Please Do Not**

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- · Send original receipts.
- Staple copied receipts to the form.
- · Write outside the boxes provided.
- Submit the same claim more than once.
- · Fax or mail this Instruction Page.

# **List of Expense Codes**

Sections 2 and 5 of the form need to specify the type of expense using one of the following:

#### **Child Care**

501 = Licensed Day Care

502 = Day Care

503 = Pre-School

504 = Day Camp

#### **Adult Care**

601 = Licensed Day Care

602 = Day Care

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SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS.)

877.841.1152

MAIL TO: BenefitWallet P.O. Box 18009, Suite A Norfolk, VA 23501

LAST FOUR DIGITS OF SSN	MAILING ZIP CODE	COMPANY NAME
PARTICIPANT LAST NAME		PARTICIPANT FIRST NAME
SECTION 2: YOUR EXPENS	SES (Use only CAPITAL LETTER	S.)
EXPENSE CODE (See page 2.)	PROVIDER NAME	
PROVIDER TAX ID OR SSN	STARTING DATE OF SERVICE (MMDDYY)	AMOUNT
		\$ .
DEPENDENT DATE OF BIRTH (MMDDYY)	ENDING DATE OF SERVICE (MMDDYY)	DEPENDENT NAME
PROVIDER AFFIDAVIT: I hereby certify (Receipts are not required if the Dependence)	•	<del>-</del>
PROVIDER'S SIGNATURE:		Date:
<b>SECTION 3: SELF CERTIFIC</b>	CATION	
		re incurred for my eligible dependents, as defined
		ses is accurate and meets the guidelines specified
		supporting IRS Regulations. I further declare that unt, or are not reimbursable under any other plan.
I understand that claims must be filed by	the claims filing deadline for the plar	year. I further understand that any person who,
		mpany, files a statement of claim containing any
materially false or misleading information,		•
I also understand that reimbursement for the current amount in my account, the rer		lance in my account. If this claim totals more than ed as additional funds are deposited.
EMPLOYEE SIGNATURE:*		Date:

DO NOT SEND ORIGINAL RECEIPTS

\*Your signature is required in order to process your claim for reimbursement.

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877.841.1152

MAIL TO: BenefitWallet P.O. Box 18009, Suite A Norfolk, VA 23501

<b>SECTION 4: YOUR INFORM</b>	ATION (Use only CAPITAL LET	TERS.)
LAST FOUR DIGITS OF SSN	MAILING ZIP CODE	COMPANY NAME
PARTICIPANT LAST NAME		PARTICIPANT FIRST NAME
SECTION 5: YOUR EXPENS	<b>ES</b> (Use only CAPITAL LETTER	(S.)
EXPENSE CODE (See page 2.)	PROVIDER NAME	
PROVIDER TAX ID OR SSN	STARTING DATE OF SERVICE (MMDDYY)	AMOUNT
		\$ .
DEPENDENT DATE OF BIRTH (MMDDYY)	ENDING DATE OF SERVICE (MMDDYY)	DEPENDENT NAME
PROVIDER AFFIDAVIT: I hereby certify (Receipts are not required if the Depend		<u> </u>
PROVIDER'S SIGNATURE:		Date:
EXPENSE CODE (See page 2.)	PROVIDER NAME	
PROVIDER TAX ID OR SSN	STARTING DATE OF SERVICE (MMDDYY)	AMOUNT
		\$
DEPENDENT DATE OF BIRTH (MMDDYY)	ENDING DATE OF SERVICE (MMDDYY)	DEPENDENT NAME
PROVIDER AFFIDAVIT: I hereby certify	that the above Dependent Core ab	arges have been incurred
	·	•
(Receipts are not required if the Depend	·	•

#### DO NOT SEND ORIGINAL RECEIPTS