Dependent Care Reimbursement Account Claim Form

BenefitWallet®

(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:

A	B	C	D		1	2	3	4

- 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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FAX TO:
877.841.1152

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

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

LAST FOUR DIGITS OF SSN

MAILING ZIP CODE

COMPANY NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS.)

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 Care charges have been incurred. (Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE: _____ Date: _____

SECTION 3: SELF CERTIFICATION

By adding my signature below, I certify that the expenses itemized above were incurred for my eligible dependents, as defined in Tax Code Section 152. I hereby declare that the description of these expenses is accurate and meets the guidelines specified under the plan as well as Internal Revenue Code Sections 125 and 129, and supporting IRS Regulations. I further declare that these expenses have not previously been paid from my reimbursement account, or are not reimbursable under any other plan. I understand that claims must be filed by the claims filing deadline for the plan year. I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information, is guilty of a crime and may be liable for substantial civil penalties.

I also understand that reimbursement for this claim is limited to the current balance in my account. If this claim totals more than the current amount in my account, the remainder of the claim will be reimbursed as additional funds are deposited.

EMPLOYEE SIGNATURE:* _____ Date: _____

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

DO NOT SEND ORIGINAL RECEIPTS

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

SECTION 4: YOUR INFORMATION (Use only CAPITAL LETTERS.)

LAST FOUR DIGITS OF SSN

MAILING ZIP CODE

COMPANY NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

SECTION 5: YOUR EXPENSES (Use only CAPITAL LETTERS.)

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 Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

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 Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE: _____ Date: _____

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