REQUEST FOR REIMBURSEMENT
DEPENDENT CARE

EMPLOYER_____

Please print or type.

Employee (Last Name, First Name, Middle Init.) _____

Email Address _____

Address _____ ❒ Check if this is a new address

Period in which care was provided:

City _____ State _____ Zip _____

From _____ To _____

Daytime Phone Number _____

$_____
AMOUNT OF CLAIM

Please have your provider sign below or staple a receipt or bill from the provider or other substantiation for the above period to the back of this claim. Please keep a copy for your records.

Names and age of Dependents for Whom Care was Provided _____

INFORMATION ABOUT THE PROVIDER OF CARE

Full Name of Provider _____

Relationship of Provider to Employee, if Any _____

Provider's Address _____

Provider's Tax ID (or Social Security Number) _____

City _____ State _____ Zip _____

Though you need not send it to us you should have a form W-10 completed by this provider in your tax records. You will need it when completing form 2441 for your income tax filing.

CERTIFICATION BY THE PLAN PARTICIPANT

As to the Maximum Benefits: This reimbursement, together with all prior reimbursements in the current plan year, will not exceed the lesser of my own earned income, or the earned income of my spouse, or $5,000.00 during the current calendar year. (If my Spouse is a full-time student or is incapable of self-care, then my spouse will be considered to have earned $200.00 per month if one dependent is being cared for, or $400.00 per month if two or more dependents are being cared for.)
As to the Provider of Care: (1) Neither myself nor my spouse can claim a dependency exemption for the provider; and (2) If the provider is one of my children, then the child was at least age 19 at the time the care was provided.
As to Services Rendered Outside the Home: If care has been provided outside the home, then (1) The care was for a child under the age of 13; or (2) the care was for my physically or mentally incapacitated dependent or spouse who was unable to care for himself or herself. The dependent or spouse regularly spends a minimum of eight hours per day in my home.

Signature of Participant_____ Date_____

RECEIPT: As an alternative to submitting a copy of your receipt for dependent care services, you may have the provider of care verify the performance of services by having them sign here.

Signature of Provider of Care_____ Date_____

SEND COMPLETED CLAIM FORM TO OUR ADDRESS:
PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION!
A FEE WILL BE CHARGED FOR ALL REQUESTED COPIES!

Benefit Administration Company (206) 625-1800
P.O. Box 550 (800) 967-3709
Seattle, WA 98111-0550 (206) 682-8016 FAX
(Note: If faxing claim **do not** mail original.)
www.benefitadministrationcompany.com

Healthcare and Dependent Care Claim Form Instructions Bulletin

REQUEST FOR REIMBURSEMENT

Prompt claim processing is largely dependent on the submittal of a properly completed *Request for Reimbursement* form (Health Care -vs- Dependent Care Reimbursement). A properly completed form includes:

- ❑ Legible personal information (employee name & current address)
- ❑ Employer Name (when not using a pre-printed form from your Employer)
- ❑ A marked change of address box, if applicable
- ❑ Legible claim description and expense information
- ❑ A legible, itemized statement and/or receipts from your provider
- ❑ An Explanation of Benefits (EOB) from all health insurance carriers
- ❑ Claim total
- ❑ Employee SIGNATURE
- ❑ A separate claim form for each plan year

CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check printing date will be processed in that check run. If you submit your claim request via facsimile, the deadline is 1:00 p.m. before the 72-hour cutoff. For example, if your plans' check printing date is Friday, the check run will include all forms received by 1:00 p.m. on Tuesday. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

Please retain a copy of your Request for Reimbursement Form, along with all supporting documentation for your itemized expenses.

CHECK STOP PAYMENT AND/OR CHECK REISSUE REQUESTS

Benefit Administration Company (BAC) will process check stop payment and/or reissue according to the following guidelines:

- ❑ All stop payment requests will be held for a minimum waiting period of ten business days from the original check release date.
- ❑ Once BAC has placed the stop payment with the financial institution, the reissued check will be held for 2 business days in accordance with the financial institution's requirement.
- ❑ **A $30 processing fee will apply for all stop payment/reissued checks not resulted from a BAC error**
- ❑ BAC will issue a replacement check for a damaged original check only after the original check has been returned to BAC

OTHER HELPFUL HINTS

- ♦ Eligible expenses are determined by the date of service, NOT the date the payment is made to the provider. Therefore, cancelled checks, bank statements, credit card receipts and provider balance forward statements are not acceptable documentation.
- ♦ A Dependent Care claim may be submitted up to 3 months in advance of services rendered
- ♦ Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- ♦ IRS rules require that the balance remaining in your reimbursement account (healthcare and/or dependent care) be forfeited at the end of the plan year.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- Health Care Spending Account: weight loss programs unless prescribed for a specific medical condition, cosmetic surgery, teeth bleaching, missed appointment and late payment fees or custodial care (nursing home)
- Dependent Care Spending Account: overnight camp, diapers and care provided while you or your spouse are not working