REQUEST FOR REIMBURSEMENT
DEPENDENT CARE

EMPLOYER: _____

Please print or type.

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

_____
Address ❒ Check if this is a new address

_____
City State Zip

_____
Email Address

Period in which care was provided:

_____ _____
From To

$_____
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

_____
Provider's Address

_____
City State Zip

_____
Relationship of Provider to Employee, if Any

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

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:

Benefit Administration Company
P.O. Box 550
Seattle, WA 98111-0550

(206) 625-1800 ext. 307
(800) 967-3709
FlexCS@baclink.com
(Note: If faxing or uploading a claim **do not** mail the original.) (206) 682-8016 FAX
https//www.benefitadministrationcompany.com

PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION!
A FEE WILL BE CHARGED FOR ALL REQUESTED COPIES!