instructions

DEPENDENT DAY CARE FSA CLAIM FORM

Mail or Fax To:
BAS
P.O. Box 62407
King of Prussia, PA 19406
FAX: 1.888.265.2144

Please type or print legibly. * Required Fields

EMPLOYEE'S NAME

* FULL NAME
* SOC. SEC. #
* EMPLOYER

WORK PH #
WORK EXT
HOME PH #

* EMPLOYEE'S STREET ADDRESS * CITY * STATE * ZIP

Please note: A separate claim form must be used for each dependent's claims.

DEPENDENT'S NAME

FULL NAME
DATE OF BIRTH
SOC. SEC. #

DEPENDENT'S STATUS

☐ HANDICAPPED
☐ FULL-TIME STUDENT

Dependent Care Expenses - Your dependent care provider must sign this form verifying charges incurred OR, you must submit a receipt from the provider for services rendered. An expense is incurred when the service is provided, not when you pay for it.

Services must be provided during the plan year and must be incurred prior to reimbursement of your claim. If you prepay your provider, you can submit this form after the first date of service. For example, if the dates of service are 4/1 through 4/30, you should not sign the form and submit the claim prior to 4/1.

Care Provider's Certification I certify, as the above listed Care Provider, that the above listed charges have been incurred.

SIGNATURE OF DEPENDENT CARE PROVIDER ______________________________ Date ____________

IMPORTANT: You are required to provide the name, address, taxpayer identification number or social security number of your dependent care provider when you file your income tax return. If you are unable to provide this information, the deduction for the Dependent Care FSA may be denied by the IRS.

CLAIM EXPENSE INFORMATION

CLAIM YEAR

* DATES OF SERVICE (MM/DD) FROM	TO	* CARE PROVIDER'S NAME	PROVIDER'S FEDERAL ID NO. (SS# OR TIN)	DESCRIPTION OF SERVICES RECEIVED	CLAIM AMOUNT
				Day Care ▼	
				Day Care ▼	
				Day Care ▼	
				TOTAL =	0.00

DEPENDENT CARE REIMBURSEMENT ACCOUNT CERTIFICATION

I certify that the Dependent Day Care expenses, submitted herewith, have been incurred for household services or for the care of a "qualifying individual" to enable me to be gainfully employed. I understand that a qualifying individual is (i) a dependent of mine under age 13, or (ii) a dependent of mine who is physically or mentally incapable of caring for himself/herself. I also certify that my Spouse, if any, was either employed, a full-time student or incapable of caring for himself/herself during the period the expenses were incurred.

I understand that if there is a discrepancy between the total amount of expenses that I requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

X

EMPLOYEE'S SIGNATURE DATE

* Benefit Allocation Systems, Inc. / MyEnroll.com does not insure benefits under this plan. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under this plan.

© 2002-2016 Benefit Allocation Systems, Inc.
Form BAS claim_form_dep_bw Ed. 01/2014