Company Name____

DAYCARE REIMBURSEMENT REQUEST FORM

NAME:	Last MI First	SS#:	
ADDRESS:	Address City , State ZIP	PHONE :	( )

☐ **Please check if this is a new address**

DAYCARE CLAIM FORM						
DATE OF SERVICE FROM	TO	DEPENDENT NAME	DEPENDENT BIRTH DATE	CLAIM AMOUNT	PROVIDER TAX ID#/SS#	*PROVIDER NAME
				$		
				$		
				$		
			Total:	$		

*There is a $25 minimum check amount – **Please make sure you sign the bottom of this form.**

RECURRING DAYCARE REIMBURSEMENT REQUEST FORM

☐ **New Recurring** ☐ **Change to Recurring**

The charge for the care is $______ **per month**, beginning on ____/____/____ & ending on ___/___/___.

Dependent Name__________________________ Dependents DOB____________________

PLEASE NOTE*: The amount reported on this form should be the actual amount paid to the provider, not the amount deducted from your paycheck.*

PROVIDER VERIFICATION

* Signature of Provider mandatory if no Federal Tax ID is given above or documentation attached.

I verify that the above charges are accurate as described.

_______________________________ _____________________ _____________________

Provider Signature Federal Tax ID Number Date

Please Note: The daycare provider must declare this as income on their tax return.

I agree that if the amount changes or if for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will notify Benefit Advantage immediately in writing.

This claim form is only valid for the current plan year and will be posted to your Flexible Spending Account at the end of the first full week of every month. Reimbursements to you will occur as funds are received by Benefit Advantage from your employer.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: ___________________________________ **Date**: _____________________

Fax to: (920) 339-0038 or (920)-339-5736

or mail to: Benefit Advantage Inc.

P.O. Box 5546, De Pere, WI 54115-5546

To view your account online: www.benefitadvantage.com

HOW TO FILE YOUR REQUEST

Definition of Dependent Care:

Must be "for care of an eligible dependent by IRS regulations enabling you or your spouse to work or to seek employment"

Definition of Eligible Dependents:

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child who is living with you and incapable of caring for him or her self.

*****The provider of the care **MUST** declare the funds you pay them as income

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DAYCARE CLAIM FORM

- ✓ Fill out only if you are manually submitting claims throughout the year
- ✓ Documentation must be attached
- ✓ Sign the bottom of the claim form

RECURRING DAYCARE

- ✓ Enter amount paid to provider per week
- ✓ Enter Begin Date of the recurring costs
- ✓ Enter End Date of plan year or date no longer have daycare costs
- ✓ Enter Dependents Name
- ✓ Enter Dependents Date of Birth
- ✓ Have Provider Sign Claim Form and enter Tax Id # or SS#
- ✓ Sign the bottom of the claim form