Employee Dependent Care Account (DCA) Claim Form

Company Name: ____

____
Employee First and Last Name

____
Home Address (Street/City/State/Zip)

____
Phone Number

DEPENDENT CARE EXPENSE REIMBURSEMENT INFORMATION:

***Read instructions on following page before completing this claim form**

Dependent Name	Age	Dates Care Provided From – To	Name, Address, Taxpayer ID Number of Care Provider	Cost for Care Provided
Dependent care expenses must be for a dependent who is incapable of self-care or under the age of 13 at the time the care was provided. Include itemized receipt of payment from the authorized care facility and submit with this claim form			Total Dependent Care Amount Requested	$

I provided the dependent care as stated above.

X_____________________________________ ______________ ____________________
Care Provider's original signature Date SSAN/Tax ID#

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's DCAP with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

____
Signature of Employee Date Signed

For Office Use Only

Claim Number: ________________________________

Dependent Care Account (DCA) Employee Claim Filing Instructions

How To File A Claim:

- Complete all information on the claim form for each amount claimed for reimbursement. If you have multiple lines of reimbursement use a second claim form.
- Make sure the claim does not include items for more than one calendar year. Use different claim forms for different years.
- You must sign and date the claim form.
- Attach a copy of the itemized receipt of payment from the authorized care facility. Signature or statement of services signed by the authorized care facility and their Tax ID number is also requirement information in order to receive reimbursement under this Plan.

Claim Form:

If you **mail** your claim with EOB's or receipts, remember to keep a copy of the claim form and supporting documents for your records.

Where To Send A Claim:

Mailing Address: Stearns HR Compliance and Consulting
Attn: Claims Department
P.O. Box 866
Sterling Heights, MI 48311

Phone: (877) 6COMPLY

Email: service@stearnshr.com