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_____ * 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	**DEPENDENT'S STATUS** ☐Over-Age Tax Dependent

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

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CERTIFICATION

I certify that the Dependent Day Care expenses submitted herewith have been incurred for daycare 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. These expenses have not been and will not be reimbursed from any other source.

X

EMPLOYEE'S SIGNATURE DATE

* Benefit Allocation Systems, LLC / MyEnroll.com does not insure benefits under your dependent day care flexible spending account plan. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the plan. Refer to the plan documents for more details.

PO Box 62407, King of Prussia, PA 19406
T.800.945.5513 F.888.265.2144
www.BASusa.com

FLEXIBLE SPENDING ACCOUNTS

Employee instructions and information for completing this claim form.

1. Complete all employee information questions.
2. Complete all dependent information questions. Submit one claim form per dependent.
3. Indicate the dates of services rendered, name of provider along with a brief description of the services and the amount of reimbursement you are requesting.
4. Itemizing Expenses vs. Entering A Grand Total. On the claim form, you have the choice of itemizing your claim expenses or entering a "Grand Total" of your claim expenses. Itemize your claim expenses if you want a detailed listing of your submission. Enter a Grand Total of your claim expenses if you simply want to indicate the total of all your claim expenses.

   If you choose to enter a Grand Total, complete the first line of the "Claim Expense Information" section as follows:

   - Dates of Service From: Enter the earliest service date of all claim expenses
   - Dates of Service To: Enter the most current date of all claim expenses
   - Health Care Provider's Name: Enter "See Receipts"
   - Description of Services: Choose "Grand Total"
   - Claim Amount: Enter the total amount of requested reimbursement

5. Once the form is completed, forward the form with the attached receipts to the above address. You should print and save your claim form for future reference.
6. A request for reimbursement which is not supported by proper documentation or does not qualify as a reimbursable expense under the employer's plan will be denied.
7. If you have questions regarding submitting your claims, please contact Benefit Allocation Systems, LLC at 1-800-945-5513 or info@BASusa.com.