DCA Claim Form

Dependent Care Assistance Account

info@benstrat.com

603-647-4668 (15 page max)

Did you know that you can:

- **File** your claim online or through our mobile app
- Click here to access your online portal
- Click here for information on our mobile app
- **Sign-up** for direct deposit online

Receipts must include:

- **Date** the expense was incurred
- **Dollar** amount of the expense
- **Provider** of Service
- **Description** of expense(s)

Employee Information:

Employee Name:
First/Last

Last Four Digits of SSN:

Primary Phone:

Employer:

Email Address:

Email is required to receive important account notifications such as claim confirmations, payment notifications and denial letters.

Dependent Care Reimbursement Expenses			
Amount to be Reimbursed	**Service Date** MM/DD/YYYY	**Description of Service**	**Person Receiving Service**
$			
$			
$			
$	Total Expenses Required		

Please attach receipts **OR** have your provider complete the **Dependent Care Provider Certification below**. **Dependent Care Provider Certification:** Provider must certify that they have provided and been paid for the above services.

Provider Name:
First/Last

Provider Signature:

Signature:

Read Carefully: The undersigned participant in the plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Dependent Care Account with respect to such expenses and that the expenses have not and will not be reimbursed under any other plan. 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 city income tax on amounts paid from the Plan with relation to such expense.

Employee's Signature:
First/Last

Date:
MM/DD/YYYY

Submission Instructions: To submit this form please click the print and sign button below after filling out all required fields, or download the form from our website and print it out to manually fill it in and either email, or fax it to the above contact information.

Print and Sign >>

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