UBT
Union Bank & Trust
HEALTH BENEFIT SOLUTIONS

Dependent Care Claim Form (DCA)

Please complete this form to submit a DCA claim. Claims may also be submitted online in our Health Benefit Solutions Portal.

Fax completed form to:
844.560.6755

Mail completed form to:
P.O. Box 82518
Lincoln, NE 68501-2518

Questions about this form?
Call 844.472.6567

Section 1: Your information

FIRST NAME | LAST NAME | LAST 4 DIGITS OF SOCIAL SECURITY NUMBER

STREET ADDRESS | CITY, STATE, ZIP CODE

EMAIL ADDRESS | PRIMARY PHONE NUMBER

DEPENDENT DAYCARE EXPENSES (Attach supporting documentation if Provider does not sign form)

Supporting documentation for dependent care expenses is required only if provider does not sign this form.

If not signed by the Provider, does your receipt include all of the following? Provider's name and address, Tax ID, Service description, Date of service, Dependent name, Amount billed. ***Credit card receipts are not acceptable**

Dependent's Name	Dependent's Age	Service Date From	Service Date To	Name & Address of Service Provider	Amount
				Total Dependent Care Expenses	

Provider Signature **Provider SSN or Tax ID#** Date

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

Participant Signature Date