

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?

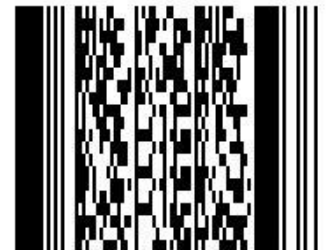
Provider's name and address, Tax ID, Service description, Date of service, Dependent name, Amount billed. ***Credit card receipts are not acceptable**

Dependent's Name	Dependent's Age	Service Date		Name & Address of Service Provider	Amount
		From	To		
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** _____



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