Spending Account Service Center
PO Box 350
Conshohocken PA 19428

Dependent Care Flexible Spending Account Claim Form

Employee Information

Employer Name			
Employee Name	Date of Birth	Employee ID Number	
Street Address	City	State	Zip Code

Dependent Care Expenses *Complete this section & attach supporting documentation.*
If you do not have supporting documentation, have provider complete next section below.

Dependent Name	Date of Birth	Relationship	Provider of Service	Provider's SSN or Tax ID #	Service Dates From / To	Amount of Expense
						$
						$
						$
						$
						$

Provider Section *This section must be completed and signed by provider if you are not attaching supporting documentation. Photocopies of previously used claim forms and/or altered claim forms will not be accepted.*
**Wet signature or verified electronic "e-signature" required.*

Provider Name and Address:		**Date(s) of Service:** From: To:	**Total Amount Billed:**
Provider SSN or Tax ID #:	**Date Signed:**	***Provider Signature**	
		Total Expenses:	

Authorization

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal tax dependent(s). Please note that domestic partners and their children are not eligible unless they are also legal tax dependents. I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses 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 up to the annual or IRS maximum.

Employee Signature: _____ Date: _____

How to File a Dependent Care Flexible Spending Account Claim

- Complete the **Employee Information** section of the claim form.
- Complete the **Dependent Care Expenses** section of the claim form.
- Attach supporting documentation. This must include an itemized bill or receipt and proof of payment if your provider does not complete the provider information on the claim form.

  Acceptable supporting documentation includes:
  - Name and address of provider
  - Tax ID Number or Social Security Number of day care provider
  - Dates of services for which you are being charged
  - Amount you are being charged
  - Provider signature – *Must be a wet signature or verified electronic "e-signature"*
- Sign and date the **Authorization** section of the claim form *(note: typed name on signature line is not sufficient*).
- Retain copies of the claim form and supporting documentation for your records. Documents submitted will not be returned to you.
- Send the completed claim form and supporting documentation to: **Spending Account Service Center.** See contact information below.

Please file all claims prior to your plan's runout deadline. It is not necessary to accumulate your claims and submit only at year-end. Promptly submitting claims allows additional information to be requested of you as soon as possible.

Note: Any items for which you are reimbursed through your Dependent Care Flexible Spending Account cannot be claimed for credits on your Federal Income Tax Return.

For more information on eligible expenses under your Dependent Care Flexible Spending Account, please refer to IRS Publication 503 or the Dependent Care Flexible Spending Account Eligible Expense List, which can be found at the Spending Account Service Center.

SAVE TIME: Submit your claim online! https://SpendingAccounts.LH1ondemand.com
Note: Your employer may have a unique link! Check your benefit materials for user access credentials.
Questions? **Call the Benefit Service Center at 1800-580-6854**

Mobile App:	**Fax to:**	**Mail to:**	**Email to:**
	800-595-4642	Spending Accounts PO Box 350 Conshohocken PA 19428	claimsubmissions@marshmma.com