REQUEST FOR REIMBURSEMENT
DEPENDENT CARE

Please print or type.

Employee (Last Name, First Name, Middle Init.) _____ Social Security Number _____

Address _____ Period in which care was provided

City _____ State _____ Zip _____ From _____ To _____

Daytime Phone (very important) _____ $_____ **AMOUNT OF CLAIM**

Please have your provider sign below or staple a receipt or bill from the provider or other substantiation for the above period to the back of this claim. Please keep a copy for your records.

Names and age of Dependents for Whom Care was Provided _____

INFORMATION ABOUT THE PROVIDER OF CARE

Full Name of Provider _____ Relationship of Provider to Employee, if Any _____

Provider's Address _____ Provider's Tax ID (or Social Security Number) _____

Though you need not send it to us or to the IRS, you should have a form W-10 completed by this provider in your tax records.

City _____ State _____ Zip _____

CERTIFICATION BY THE PLAN PARTICIPANT

As to the Maximum Benefits: This reimbursement, together with all prior reimbursements in the current plan year, will not exceed the lesser of my own earned income, or the earned income of my spouse, or $5,000.00 during the current calendar year. (If my Spouse is a full-time student or is incapable of self-care, then my spouse will be considered to have earned $200.00 per month if one dependent is being cared for, or $400.00 per month if two or more dependents are being cared for.)
As to the Provider of Care: (1) Neither myself nor my spouse can claim a dependency exemption for the provider; and (2) If the provider is one of my children, then the child was at least age 19 at the time the care was provided.
As to Services Rendered Outside the Home: If care has been provided outside the home, then (1) The care was for a child under the age of 13; or (2) the care was for my physically or mentally incapacitated dependent or spouse who was unable to care for himself or herself. The dependent or spouse regularly spends a minimum of eight hours per day in my home.

Signature of Participant_____ Date_____

RECEIPT: As an alternative to submitting a copy of your receipt for dependent care services, you may have the provider of care verify the performance of services by having them sign here.

Signature of Provider of Care_____ Date_____

SEND COMPLETED CLAIM FORM TO OUR ADDRESS:
PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION!
A FEE WILL BE CHARGED FOR ALL REQUESTED COPIES!

Benefit Administration Company (206) 625-1800
P.O. Box 550 (800) 967-3709
Seattle, WA 98111-0550 (206) 682-8016 FAX
(Note: If faxing claim **do not** mail original.)
www.baclink.com