City & Borough of Juneau

REQUEST FOR REIMBURSEMENT
DEPENDENT CARE

Please print or type.

Last Name, First Name, MI
Employee (Last Name, First Name, Middle Init.)

000-00-0000
Social Security Number

Street Address
Employee's Address check here if new address

Period in which care was provided

City, State, Zip
City State Zip

From To

(000) 000-0000
Daytime Phone (very important)

$0.00
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.

Enter Names and Ages of Dependents
Names and age of Dependents for Whom Care was Provided

INFORMATION ABOUT THE PROVIDER OF CARE

Enter Provider Name
Full Name of Provider

Enter Provider Relationship
Relationship of Provider to Employee, if Any

Enter Provider Address
Provider's Address

Enter Provider Tax ID or
Provider's Tax ID (or Social Security Number)

Enter Provider City, State, Zip
City State Zip

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.

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. THIS MUST BE AN ORIGINAL SIGNATURE!

Signature of Provider of Care _____ Date _____

SEND COMPLETED CLAIM FORM TO OUR ADDRESS:

BAC

Benefit Administration Company (206) 625-1800
P.O. Box 550 (800) 758-1982
Seattle, WA 98111-0550 (206) 682-8016 FAX
(Note: If faxing claim do not mail original. Day Care Account claims that require a signature of provider must be mailed.)