DEPENDENT DAY CARE FSA CLAIM FORM

MyEnroll.com

Mail or Fax To:
BAS
P.O. Box 62407
King of Prussia, PA 19406
FAX: 1.888.265.2144

Please type or print legibly. * Required Fields

EMPLOYEE'S NAME
* FULL NAME ____________________
* SOC. SEC. # * EMPLOYER

WORK PH #
WORK EXT
HOME PH #

EMPLOYEE'S STREET ADDRESS * CITY * STATE * ZIP

DEPENDENT'S NAME
FULL NAME ____________________
DATE OF BIRTH SOC. SEC. #

DEPENDENT'S STATUS
☐ HANDICAPPED
☐ FULL-TIME STUDENT

Dependent Care Expenses - Your dependent care provider must sign this form verifying charges incurred OR, you must submit a receipt from the provider for services rendered. An expense is incurred when the service is provided, not when you pay for it. Services must be provided during the plan year and must be incurred prior to reimbursement of your claim. If you prepay your provider, you can submit this form after the first date of service. For example, if the dates of service are 4/1 through 4/30, you should not sign the form and submit the claim prior to 4/1.

Care Provider's Certification I certify, as the above listed Care Provider, that the above listed charges have been incurred.

SIGNATURE OF DEPENDENT CARE PROVIDER ____________________ Date __________

IMPORTANT: You are required to provide the name, address, taxpayer identification number or social security number of your dependent care provider when you file your income tax return. If you are unable to provide this information, the deduction for the Dependent Care FSA may be denied by the IRS.

CLAIM EXPENSE INFORMATION

CLAIM YEAR ☐ * DATES OF SERVICE (MM/DD)		* CARE PROVIDER'S NAME	PROVIDER'S FEDERAL ID NO. (SS# OR TIN)	DESCRIPTION OF SERVICES RECEIVED	CLAIM AMOUNT
FROM	TO				
				TOTAL =	

DEPENDENT CARE REIMBURSEMENT ACCOUNT CERTIFICATION

I certify that Dependent Care expenses, if submitted herewith, have been incurred for household services or for the care of a "qualifying individual" to enable me to be gainfully employed. I understand that a qualifying individual is (i) a dependent of mine under age 13, (ii) a dependent of mine who is physically or mentally incapable of caring for himself/herself. I also certify that my Spouse, if any, was either employed, a full-time student or incapable of caring for himself/herself during the period the expenses were incurred.

I understand that if there is a discrepancy between the total amount of expenses that I 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.

X ____________________

EMPLOYEE'S SIGNATURE DATE

* Benefit Allocation Systems, Inc. / MyEnroll.com does not insure benefits under this plan. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under this plan.

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Benefit Allocation Systems

132 Ivy Lane, PO Box 62407, King of Prussia, PA 19406
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www.BASusa.com

FLEXIBLE SPENDING ACCOUNTS

Employee instructions and information for completing this claim form.

1. Complete all employee information questions.
2. Complete all dependent information questions, if the claim expenses are for a dependent, (submit one claim form per dependent).
3. Indicate the dates of services rendered, name of provider along with a brief description of the services and the amount of reimbursement you are requesting.
4. When requesting reimbursement for medical expenses, a copy of the explanation of benefits provided by any insurer or claims processor must also be attached when coordination of benefits is involved.
5. Be sure to attach itemized receipts for all items claimed. Claims without itemized receipts will be declined.
6. Once the form is completed, forward the form with the attached receipts to the above address.
7. The provisions of this plan reserve to the Administrator and the Claims Processor the right to reject requests for reimbursement which they believe are not supported by proper documentation or do not qualify as reimbursable expenses under this plan.
8. If you have any further questions regarding submitting your claims, please contact a BAS Benefits Counselor at 1-800-945-5513 or visit BAS at www.BASusa.com.