SelectAccount℠

☐ ✔ if this is a resubmission ☐ ✔ if new address

DAYCARE EXPENSE REIMBURSEMENT CLAIM FORM

Use this form for dependent child or adult daycare expenses.

Complete when faxing: # of pages _____

To expedite reimbursement, fax this form to 1-866-231-0214. This form serves as the cover page.

Each field must be completed or the processing of your claim will be delayed or denied. See the reverse side for eligibility and submittal information.

SECTION A – Account Holder Information (PLEASE PRINT)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SELECTACCOUNT ID# SA
STREET ADDRESS			SOCIAL SECURITY # (if SA# not known)
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER ( )
ACCOUNT HOLDER'S EMAIL ADDRESS		EMPLOYER NAME	

SECTION B – Claim Detail (PLEASE PRINT)

Date(s) of Service	Full Name of Person(s) Receiving Service	Age(s)	Reimbursement Requested
- - to - -			$
- - to - -			$
- - to - -			$
- - to - -			$
- - to - -			$
		TOTAL	$

SECTION C – Daycare Provider Information

For expenses to be eligible this section must be completed and signed by the Provider of dependent care services or attach documentation from the Provider. This signature verifies that I am an eligible provider, the claim details above are accurate, and the account holder is being billed for these services.

PROVIDER NAME	PROVIDER SIGNATURE
TAX I.D. NUMBER OR SOCIAL SECURITY #	DATE

SECTION D – Account Holder Signature

I authorize the above expenses to be reimbursed from my Dependent Care Reimbursement Account. To the best of my knowledge, my statements in this form are true and complete. I certify all of the following: My family member has received the services described above on the date(s) indicated, and the expenses qualify as valid Dependent Care Expenses. The expenses listed are for my Dependent. These expenses have not previously been reimbursed under the Dependent Care Reimbursement Account or any other plan, and I will not seek reimbursement for them under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deductible or credit (such as the Dependent Care Tax Credit). I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification number. The amount of reimbursement requested in this form, added to the reimbursements to date, do not exceed the statutory limits. I have read, understood and make the certifications contained in the Daycare Expense Reimbursement Claim Form above.

ACCOUNT HOLDER SIGNATURE	DATE

RETURN THIS FORM TO: SelectAccount
ATTN: Account Administrator
P.O. Box 64193
St. Paul, MN 55164-0193
FAX: 651-662-7247 / 1-866-231-0214

FORMS AVAILABLE:
www.selectaccount.com
or by calling
SelectAccount
Customer Service

CUSTOMER SERVICE:
651-662-5065
1-800-859-2144
7 am - 7 pm, M-F

F8420R04 (5/09)