Dependent Care FSA Claim Form

MAIL:
PO BOX 7500
CHAMPAIGN, IL
61826-7500

PHONE:
217-531-9000
877-272-8880

FAX:
217-239-4499
800-295-2990

ONLINE:
www.bpcinc.com

Participant Employer: _____

Participant Name (please print): _____ SSN: XXX-XX- _____

Email Address: _____ Day Time Phone Number: _____

Spouse's Name: _____ Spouse's SSN: XXX-XX- _____ Spouse's Employer: _____

☐ I have Changed My Address To: _____

Street City State Zip

NOTE: IRS regulations allow payment of services for dependents under age 13 and/or otherwise Qualifying Individuals as defined in the Plan document. The expenses must be incurred while you (and your spouse, if you are married) are at work or going to school. There is an exception if your spouse is not working or looking for work, then he or she must be a fulltime student or be physically or mentally incapable of self-care.

Dependent Name	DoB	Age	Provider Name	Dates of Service (From - To)	Amount Requested
					$
					$
					$
					$
					$
					$

AFFIDAVIT:
Your care provider(s) only need to sign this if you do not have supporting documentation, such as an itemized receipt. I hereby certify that I provided adult or child daycare services to the above individuals in accordance with the amounts and dates that are requested.

Provider Signature _____ Date Submitted _____

Provider Signature _____ Date Submitted _____

Provider Signature _____ Date Submitted _____

*A check will not be issued until **$25.00** in eligible claims have been received.*

PLEASE READ CAREFULLY: By my signing below, I authorize the above expenses to be reimbursed from my DCAP 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 dates indicated which is after the date I elected to receive DCAP Benefits and during the Plan Year to which the election applies. The expenses qualify as valid Dependent Care Expenses as defined in the Plan document. The expenses listed are for a Qualifying Individual as defined in the Plan. These expenses have not previously been reimbursed under the DCAP or any other plan, and I will not seek for them under insurance or any other Plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Tax Credit). I agree to file IRS form 2441 with my tax return and provide any required provider information including taxpayer identification numbers. I can only be reimbursed for my Dependent Care expenses after the date of service has passed. If my DCAP balance is less than the amount requested, the difference will be held until the balance in my account is sufficient to pay these expenses.

Participant Signature: _____ Date Submitted: _____

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bpcinc.com/login

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bpcinc.com/contact