SelectAccount[SM]

DAYCARE EXPENSE REIMBURSEMENT CLAIM FORM

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

Use this form for dependent child or adult daycare expenses.

Complete when faxing: # of pages _____

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

SECTION A - Account Holder Information (PLEASE PRINT)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SELECT ACCOUNT ID#
			SA
STREET ADDRESS			SOCIAL SECURITY # (if SA# not known) - -
CITY	STATE	ZIP CODE -	DAYTIME PHONE NUMBER ( ) -
			EMPLOYEE ID # (if applicable)

EMPLOYER'S NAME

SECTION B - Claim Detail (PLEASE PRINT)

*Required information - if information is missing, the processing of your claim may be delayed.

*Date(s) of Service	*Full Name of Person (s) Receiving Service	*Relationship to Account Holder	*Age(s)	*Reimbursement Requested
- - to - -				$
- - to - -				$
- - 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.

Total expenses incurred for services rendered to the individual(s) on the date(s) specified in Section B. $

This signature verifies that I am an eligible provider. See reverse side for eligibility information.

PROVIDER NAME	TAX I.D. NUMBER OR SOCIAL SECURITY #	PROVIDER SIGNATURE	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. See reverse side for eligibility information. 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 / (866) 231-0214

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

CUSTOMER SERVICE:
(651) 662-5065
(800) 859-2144

HOW TO FILE A CLAIM

To receive reimbursement for eligible expenses, fax **OR** mail (not both) a completed claim form along with IRS-required documentation. To expedite your request, fax your claim form and supporting documentation. **Documentation of the expense must include all of the following:**

- date of service
- name of person receiving service
- age of person(s) receiving the service
- name of provider of service
- type of service provided
- amount charged for each service
- provider's Social Security Number or Tax ID#
- provider's signature

***CANCELLED CHECKS DO NOT QUALIFY AS THIRD-PARTY DOCUMENTATION AND ARE NOT ACCEPTED BY THE IRS.**

Be sure to complete the form in its entirety. If the form is incomplete or unsigned, your claim request will be delayed. You will be reimbursed up to your account balance for all eligible dependent care expenses according to your employer's claim processing schedule.

Do not highlight your claim form or any supporting documentation, as it will interfere with our claims processing system.

Fax Tips

✓ Complete claim form using a dark pen (do not use a pencil).
✓ If your documentation is printed on dark paper, copy it onto lighter paper.
✓ Confirm successful transmission.

Mailing Tips

✓ Do not staple.
✓ Neatly tape any small receipts onto an 8.5 x 11 sheet of paper.
✓ Do not mail originals. Keep a copy for your records.

ELIGIBILITY INFORMATION

* Care must be for a child under age 13, unless they are incapable of self care (annual letter of medical necessity required).
* Care must be provided by an individual age 19 or older with a tax ID or Social Security Number.
* Care must allow the parent(s) to be gainfully employed.
* Care must be custodial in nature, not recreational.

INELIGIBLE SERVICES

* Kindergarten Expenses
* Overnight camp
* Care provided by a family member under the age of 19
* Care provided by a parent or family member that can be claimed as a dependent of the parent.

COMPLAINT/APPEAL INFORMATION

The Payment Activity Report you receive by mail will explain how your claim was processed based upon the information submitted to us. You or your designated representative may appeal a denial, partial denial, or reduction of your claim by following our complaint procedures. First, contact customer service for an explanation. If you are not satisfied with the explanation given, we will send you a form to file your complaint. You may also submit any documents, records, or other information that relates to your claim for benefits. Upon receipt of your request, we will provide a full and fair review of your complaint and a written notice of our decision according to the timeframe found in your Plan documentation.

If you are a member of a group plan that is subject to the Employee Retirement Income Security Act (ERISA), once you have exhausted our complaint/appeal process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.