BENEFITHELP
Solutions

Dependent Care Flexible Spending Account Claim Form
Public Employees' Benefit Board
Group #8743

(*Please Print*)

Employee Benefit Number
P followed by 8 numbers _____

Employee Name: _____
(Last) (First) (MI)

Home/Mailing Address: _____
(Street)

☐ CHECK HERE IF NEW _____
(City) (State) (Zip)

IMPORTANT - Instructions for completing a claim form:

1. Complete the entire claim form, including signature and date. Failure to complete the form in its entirety (including the itemization of each expense), and attaching supporting documentation may result in a delay in processing your claim. If you require more space please attach a separate sheet that includes the same information as on the form.
2. Attach supporting documentation. Canceled checks, credit card receipts, statements, balance forward or balance due statements are not acceptable.
   - To submit dependent care expenses, attach documentation that includes the date(s) of service, the name of the provider, the tax ID# or social security number of the provider. The name of the dependent who the care was for and the amount of the charge(s). Childcare expenses are for IRS tax dependents under the age of 13. Adult care expenses are for IRS tax dependents residing in the participant's home. Educational and Kindergarten expenses or after school activities (ballet, soccer, karate) are not eligible for reimbursement.
3. Keep a copy of the completed claim form and supporting documentation for your files.
4. Change in Reimbursement Process - Dependent care reimbursement may be made only for completed services. To separate the reimbursement period and because you cannot receive payment until all dates of services have been rendered, you may want to submit your claim on a weekly or bi-weekly basis.
5. New Grace Period allows you to submit claims from the new plan year and receive reimbursement from previous year left over funds. The Grace Period runs from January 1– March 15.
6. All claims must be submitted by March 31 including the Grace Period Claims for reimbursement.
7. For reassignment of claims processed in the grace period, please complete the Claim Reallocation Form. For assistance contact BenefitHelp Solutions.

Dependent Care Expenses - Use *a separate line for each expense. Attach a separate sheet if needed. Attach supporting documentation as explained above in 2, or have your dependent care provider sign below. Dependent care provider cannot be an IRS tax dependent or a dependent under the age of 19.*

Name of Dependent	Age	Period Covered From mm/dd/yy	Period Covered To mm/dd/yy	Provider Name, Address & Tax ID or SSN	Amt Requested	INTERNAL USE
				TOTAL:		

The total amount has been paid for dependent care expenses for the stated time period.

_____ _____ _____
Dependent Care Provider Signature | Tax ID# or SS# | Date

I request reimbursement from my Flexible Spending Account for the listed expenses paid by me. I certify these expenses are not covered by or reimbursable from any other source. I understand that I cannot use expenses reimbursed through the dependent care account to claim as a tax credit when filing income tax returns. I understand the limitations and qualifications and federal regulations of this program.

Participant's Signature: _____ Date: _____

R09/06

Submit this Claim Form and supporting documentation to:
BenefitHelp Solutions, Attn: FSA, PO Box 67230, Portland, OR 97268 or Fax: 503-765-3554 or 1-877-277-7279
www.benefithelpsolutions.com