



# Benefit Advantage

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TOWN OF GRAND CHUTE

Company Name: \_\_\_\_\_

## Dependent Care CLAIM FORM

<b>NAME:</b>	Last	MI	First	<b>SS#:</b>	
<b>ADDRESS:</b>	Street	City	State	ZIP	<b>PHONE :</b> ( )

Please check if this is a new address

### DAYCARE CLAIM FORM

DATE OF SERVICE FROM	DATE OF SERVICE TO	DEPENDENT NAME	DEPENDENT BIRTH DATE	CLAIM AMOUNT	PROVIDER TAX ID#/SS#	*PROVIDER NAME
				\$		
				\$		
				\$		
<b>Total:</b>				\$		

Dependent Care expenses are reimbursed up to the cash balance in your account. Unpaid claims are reimbursed as more funds are received from your employer and credited to your account.  
**There is a \$25 minimum payment amount.**

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of \$10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the \$10.00 fee.

### PROVIDER VERIFICATION

Signature of the Provider is mandatory if no Federal Tax ID is given above or documentation attached and the daycare provider must declare this as income on their tax return.

I verify that the above charges are accurate as described.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Federal Tax ID Number

\_\_\_\_\_  
Date

### EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this Dependent Care Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

You may review your account at [www.benefitadvantage.com](http://www.benefitadvantage.com) for balance details.