



## Dependent Care Affidavit & Claim Form

Today's Date: \_\_\_\_\_ Plan year beginning for: 20\_\_\_\_\_ Number of pages: \_\_\_\_\_

New Claim	Resubmission of claim	Response to claim denial
<b>Employer Name (Do not abbreviate)</b>		
<b>Employee Full Name</b>		<b>Social Security No. (last 4 digits)</b>
<b>Employee Street Mailing Address</b>		<b>City, State Zip Code</b>
<b>Email Address</b>		<b>Mobile Phone</b>

Check here if change of information above.

Dependent Care Provider/ Company Name	Tax ID/SSN	Dependent receiving care	Dates of Service	Amount
<b>Total Amount Requested:</b>				

By signing, the Dependent Care Provider certifies that the service(s) above were rendered during the date(s) provided and for the amount listed. You are also confirming that this claim does not include ineligible items. Some ineligible items include food costs, overnight camp, school tuition and late fees.

Dependent Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that the expenses being submitted were incurred while covered under the Company's pre-taxable benefit accounts and have not been reimbursed by any other source. If the claim is not valid, I recognize that I will be required to repay any expense amounts that are incorrectly reimbursed. I also recognize that I cannot claim these expenses on my personal income tax return.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

This form does not require corresponding Itemized Receipts to approve transaction. However, in the event of an IRS Audit you will be required to provide supporting documentation. Send completed DCA Affidavit/claim form to:

<p><b>THE HARRISON GROUP, INC.</b>  3 Raymond Drive, Suite 201 · Havertown, PA 19083  Fax 610-853-9079 · Email <a href="mailto:service@theharrisongrouponline.com">service@theharrisongrouponline.com</a></p>
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