# 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 |
|---|---|---|

| **Employer Name (Do not abbreviate)** | |
|---|---|
| **Employee Full Name** | **Social Security No. (last 4 digits)** |
| **Employee Street Mailing Address** | **City, State Zip Code** |
| **Email Address** | **Mobile Phone** |

__ Check here if change of information above.

| Dependent Care Provider/ Company Name | Tax ID/SSN | Dependent receiving care | Dates of Service | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Total Amount Requested:** | | | | |

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 if signed by the Dependent Care Provider above. However, in the event of an IRS Audit you will be required to provide supporting documentation. Send completed DCA Affidavit/claim form to:

THE HARRISON GROUP, INC.
3 Raymond Drive, Suite 201 · Havertown, PA 19083
Fax 610-853-9079 · Email service@theharrisongrouponline.com