SelectAccount℠

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

DAYCARE EXPENSE REIMBURSEMENT CLAIM FORM

Use this form for dependent child or adult daycare expenses.

Complete when faxing: # of pages _____
To expedite reimbursement, fax this form to 1-866-231-0214. This form serves as the cover page.

Each field must be completed or the processing of your claim will be delayed or denied.
See the reverse side for eligibility and submittal information.

SECTION A – Account Holder Information (PLEASE PRINT)

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

SECTION B – Claim Detail (PLEASE PRINT)

Date(s) of Service	Full Name of Person(s) Receiving Service	Age(s)	Reimbursement Requested
- - 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. This signature verifies that I am an eligible provider.

PROVIDER NAME	PROVIDER SIGNATURE
TAX I.D. NUMBER OR SOCIAL SECURITY #	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. 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
7 am - 7 pm, M-F

HOW TO FILE A CLAIM

To receive reimbursement for eligible expenses, fax **OR** mail (not both) a completed claim form. To expedite your request, fax your completed claim form.

Be sure to complete the form in it's entirety. If the form is incomplete or unsigned, your claim request will be delayed or denied.

You will be reimbursed up to your account balance for all eligible dependent care expenses according to your employer's claim processing schedule.

Per IRS regulations, supporting documentation is not required with your claim. Keep documentation for your tax records.

Submission Tips

✔ Complete claim form using a dark pen (do not use a pencil).
✔ **Do not highlight** your claim form as it will interfere with our claims processing system.
✔ If your documentation is printed on dark paper, copy it onto lighter paper.
✔ Confirm successful fax transmission.
✔ 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 found at www.selectaccount.com).
- Care must be provided by an individual with a tax ID or Social Security Number.
- Care must allow the parent(s) to be gainfully employed.
- Care must be custodial in nature.

INELIGIBLE SERVICES

- School Expenses including Kindergarten.
- 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.
- Activity fees
- Late payment fees

APPEAL INFORMATION

The Explanation of Processing Report explains 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 appeal procedures. You may contact customer service at 1-800-859-2144 or 651-662-5065 for an explanation of your appeal rights. If you disagree with our decision on your claim, you have the right to submit a written request for an appeal review to SelectAccount, P.O. Box 64193, St. Paul, MN 55164-0193. We can send you a form to file your appeal or you can obtain a copy of the appeal form at www.selectaccount.com. You have until the later of your plan's run out end date or 180 days from the date of this notice to file an appeal. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or contact our customer service department. 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 appeal and a written notice of our decision either by letter or an explanation on the Explanation of Processing Report within 30 days.

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 appeal process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.