DFB
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DEPENDENT CARE ASSISTANCE (DCA) PLAN
REIMBURSEMENT CLAIM FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ Employer: _____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

2. DEPENDENT CARE EXPENSES

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period
		From	To*		
		Total Dependent Care Amount Requested		→	

I provided the dependent care as stated above.

x_____ _____ _____

Care Provider's **original** signature Date SSAN/Tax ID#

3. TERMS AND CONDITIONS

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's DCAP with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Employee's Signature Date

SUBMIT YOUR COMPLETED CLAIM FORM TO: **Fax:**248-588-4188 or claims@dfbtpa.com
Or Mail to:
DFB TPA FSA Claims
PO BOX 71027
Madison Heights MI 48071

Notice: All employees participating in a Section 129 Dependent Care Assistance Plan are required to file Form 241 with the IRS by April 15 of the year following your participation in this plan.