PLEASE MAKE COPIES OF THIS FORM FOR FUTURE CLAIMS

DCRA
REIMBURSEMENT REQUEST FORM
Dependent DayCare Expenses Only

For Qualifying Dependent Care Reimbursement Account (DCRA) Babysitting Expenses/Elder Daycare Expenses

NOTE: This form MUST be completed to receive reimbursement for out-of-pocket Dependent Daycare expenses for your Dependent Daycare Account(s). These services MUST have been incurred during the current Plan Year. **An itemized copy of the provider's itemized bill/receipt verifying the name of the care provider, the provider's Tax ID or Social Security Number and signature, and the date(s) of service MUST be attached to the back of this form.** *Your claim will not be processed until these items are received by MGIS.* ***Credit card receipts cannot be accepted.***

FAX COMPLETED FORM AND ALL DOCUMENTATION TO:

MEDICAL GROUP INSURANCE SERVICES, INC.
CLAIMS FAX: 866.969.4446

PLEASE COMPLETE ENTIRE FORM. PRINT OR TYPE. (USE ADDITIONAL SHEETS IF NECESSARY.)

EMPLOYER NAME:	**PLAN YEAR:**
EMPLOYEE NAME: _____ (LAST / FIRST / MI)	**SOCIAL SECURITY NUMBER:** _____-_____-_____
EMPLOYEE HOME ADDRESS: _____ (NUMBER AND STREET) _____ (CITY) _____ (STATE) _____ (ZIP) ❑ CHECK HERE IF THIS IS A CHANGE IN ADDRESS	
EMPLOYEE DAY PHONE: ( )	**EMPLOYEE E-MAIL:**

UNREIMBURSED DAYCARE EXPENSES

(QUALIFYING BABYSITTING EXPENSES/ELDER DAYCARE EXPENSES)

See IRC Section 129 for qualifying Dependent Care expenses or consult your tax advisor for more information.

COVERED PERIOD		PERSON WHO RECEIVED CARE	DATE OF BIRTH	AGE AT TIME OF SERVICE	CARE PROVIDER NAME	AMOUNT
START DATE	END DATE					
Credit card receipts or cancelled checks cannot be accepted.						
					TOTAL UNREIMBURSED DCA CLAIMS	$

CARE PROVIDER INFORMATION

THIS SECTION MUST BE COMPLETED FOR REIMBURSEMENT

BABYSITTER INFORMATION	DAYCARE CENTER INFORMATION
NAME: _____	**DAYCARE CENTER NAME:** _____
ADDRESS: _____	**ADDRESS:** _____
SOCIAL SECURITY #: _____	**TAX ID#** _____
DAYCARE PROVIDER'S SIGNATURE (REQUIRED)	

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Dependent Care Assistance Plan Account. I am claiming reimbursement only for eligible expenses incurred by myself for my spouse and/or covered dependents (for DCA reimbursement, these expenses must have been incurred during the Plan Year shown above) and certify that these expenses have not been reimbursed under this Plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my Dependent Care Account to be reduced by the amount(s) shown above.

PARTICIPANT'S SIGNATURE X _____ DATE _____

If you have questions or need assistance, call the number listed below or visit our website.