




Please complete, sign and date this claim form. Attach all the appropriate documentation. Your plan is governed by IRS guidelines. In order to satisfy IRS requirements certain documentation is needed to process claims. Lack of the Employee's Social Security Number, missing information and/or insufficient documentation will delay the processing of your claim.

<b>PART A: CLAIMANT DATA</b> (please print)			
<b>COMPANY NAME:</b>			
EMPLOYEE'S LAST NAME	EMPLOYEE'S FIRST NAME	MI	Employee's Social Security
Employee's Mailing Address (Street or PO BOX) <input type="checkbox"/> Check here if this is an address change			Apt. #
City	State	Zip	
How should we contact you with questions regarding your claim? <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Email: _____			

<b>PART B: DEPENDENT CARE PROVIDER</b> (IF YOU DON'T HAVE A RECEIPT THIS SECTION MUST BE COMPLETED)				
Provider's Name			Providers SS# OR Tax ID#	
Street	Apt. #	City	State	Zip Code
I hereby authorize that I have or will provided the services as listed below (providers signature) x _____				Date: _____

<b>Part B: REIMBURSEMENT METHOD</b>	
<input type="checkbox"/> Mail me a check via US postal service <input type="checkbox"/> Directly Deposit it into my checking or savings account Direct Deposit (ACH): When filing claims manually, I hereby authorize The Choice Care Card to Credit the account indicated below: Account Number: _____ Routing Number (9 digits): _____ Type of Account:    Checking            Savings	

<b>PART D: DEPENDENT AND REIMBURSEMENT INFORMATION</b>				
Dependent Name	Date of Birth	Relationship	Future Dates of Service	Amount of Charge
<b>Total:</b>				\$ _____

**PART E: CLAIM SUBMISSION**

Preferred Method: email to [claims@choicecarecard.com](mailto:claims@choicecarecard.com)  
 Alternative Methods: The Choice Care Card | 76 McNeil Road | 2<sup>nd</sup> Floor | Waterbury Ctr, VT 05677 | Fax 1-802-244-2020

**PART F: EMPLOYEE STATEMENT**

I understand that I can only be reimbursed for services with funds that have been deposited into my Dependent Care account for that plan year. Checks will be made payable to me and mailed to the address indicated on this form. If I have elected to have my funds directly deposited into my bank account, I have previously provided ACH information, or have done so on this form.

I understand that I am solely responsible for notifying The Choice Care Card of any changes to this request for reimbursement, such as change of custodial care provider or a change in my Dependent Care account election. I will report any amounts paid for dependent care on IRS Form 2441 when I prepare my annual tax return. My employer will report the amount that was withheld from my pay for dependent care expenses on my W-2. Failing to provide accurate information may subject me to tax consequences in the event of an IRS audit.

I hereby certify that the information contained in Part D, Dependent and Reimbursement Information, is true and correct to the best of my knowledge and belief. I understand that I am responsible for providing proof to support each claim expense submitted for reimbursement. Any reimbursed expense later discovered to be ineligible for reimbursement will be taxable to me. In addition, I understand that expenses paid for with pre-tax dollars from my plan cannot be claimed on my income tax return. I will not include amounts paid or eligible for payments under any other health care plan or program, federal, state, or government program, workers' compensation or any other policy of health insurance.

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