



INNOVATION IN BENEFITS

2300 Renaissance Boulevard
King of Prussia, PA 19406

Dependent Care
Claim Form



DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Employee Information

Name	Date of Birth	Employee Identification Number	
Street Address <input type="checkbox"/> <i>New Address</i>	City	State	Zip Code
Home Phone Number (including area code)	Work Phone Number (including area code)		

Dependent Care Expenses (For services rendered in a licensed Day Care Facility)

Dependent Name	Date of Birth	Relationship	Provider of Service	Provider's Tax ID	Service Dates From To	Amount of Expense	Suffix (office use)
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	
Total:						\$	

Dependent Care Expenses (For services rendered in other than a licensed Day Care Facility)

Name, address, and relationship to employee of provider of service				Provider Social Security or Tax ID Number			
Dependent Name	Date of Birth	Relationship	Service Dates From To	Amount of Expense	Suffix (office use)		
				\$			
				\$			
				\$			
Total:				\$			

Authorization

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature: _____ Date: ____/____/____

See Reverse for Additional Information

How to File a Dependent Care Claim

Step One

- Please read the Eligibility Requirements for Reimbursement of Dependent Care Expenses listed in your benefits booklet.

Step Two

- Complete the **Employee Information** section of the claim form.

Step Three

- Complete the section titled **Dependent Care Expenses** applicable to the type of dependent care provider. Please remember to include the provider's tax ID # or SSN.

Step Four

- **Attach supporting documentation, which must include an itemized bill.**
 - Name and address of the day care provider
 - Tax ID Number or Social Security Number of day care provider
 - Dates of services for which you are being charged
 - Amount you are being charged
 - **Services will not be reimbursed for advanced payment.** Services must be rendered before reimbursement may be made
 - **Payment statements are not sufficient documentation.** The Dates of Service must be listed. Canceled checks are not sufficient documentation.

Step Five

- Send the fully completed claim form and supporting documentation to:

TRION™
FSA Claims Processing
2300 Renaissance Boulevard
King of Prussia, PA 19406

Or fax your claims to (800) 291-9629

- Retain copies of the entire claim form and supporting documentation for your records. Those submitted will not be returned to you.

Please visit www.EnrollOnline.com to view your claim and check status. Access information is provided on your Welcome Letter.

Note: Any items for which you are reimbursed through your Dependent Care Account cannot be claimed for credits on your Federal Income Tax Return.

For more information on eligible expense under your Dependent Care Spending Account, please refer to US Code: Title 26, Section 129 issued by the Department of the Treasury/Internal Revenue Service, which can be obtained at most public libraries.

For questions regarding Dependent Care Spending Accounts, please contact us at 1-866-806-0949.