AMERICAN BENEFITS GROUP

DEPENDENT CARE ASSISTANCE PLAN – RECEIPT FOR SERVICES

Use this form only if your provider does not provide you with a statement for their services.

Submit this form with a claim form to be reimbursed (next page).

Member Name:_____ Last 4 digits of SSN: _____

Employer: _____

Provider Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Provider's Federal Tax ID Number or SSN: _____

I, _____ , provided day care services for_____
PROVIDER'S NAME NAME(S) OF QUALIFIED DEPENDENT(S)*

_____

_____

For the date(s) of: _____
SPECIFIC DATE OR RANGE OF DATES

In the amount of: _____
TOTAL AMOUNT PAID

Provider Signature: _____ Date: _____

* Note: Qualified Dependents are generally children under age 13 whom you can claim on your federal tax return. If a child turns 13 during the year, the child is a Qualified Dependent only for the part of the year he or she was under age 13. Other Qualified Dependents are disabled persons who are not physically or mentally able to care for themselves whom you can claim as a dependent on your federal tax return.

Fax Toll Free: 877-723-0147 or securley **email to** claims@amben.com

No Fax Machine?

Mail to: American Benefits Group, PO Box 1209, Northampton, MA 01061-1209

AMERICAN BENEFITS GROUP

CLAIM FOR REIMBURSEMENT

Please make copies and save for future claims filing

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Email: _____

Dependent Care/Day Care Expense Claims

Name of Dependent(s)	Period Covered From	To	Name and Taxpayer Identification Number of Service Provider	Amount Incurred
			TOTAL DEPENDENT CARE EXPENSE CLAIM	$

Medical Expense Claims *(for you and/or your eligible dependents)*

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred	FSA	HRA	Amount Incurred
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
			TOTAL MEDICAL CARE EXPENSE CLAIM			$

READ CAREFULLY

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 the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed and will not be reimbursed under any other health plan coverage. 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 city income tax on amounts paid from the Plan which relates to such expense.

Employee's Signature: _____ Date: _____

Please submit this claim form along with substantiating receipts or for HRAs Explanation of Benefits (EOB).
(*Receipts must indicate the dates of service, the name of the provider, the nature of the service rendered or product purchased,the person for whom the service was provided and the cost of the service)*

The easiest way to submit claims is through your online account via the WealthCare Portal or WealthCare Mobile.

WealthCare Portal: www.amben.com/wealthcare

WealthCare Mobile: www.amben.com/wealthcaremobile

Fax Toll Free: 877-723-0147

Mail to: American Benefits Group, PO Box 1209, Northampton, MA 01061-1209 800-499-3539