DEPENDENT CARE ASSISTANCE PROGRAM
CLAIM REIMBURSEMENT FORM

Office of the State Comptroller
Healthcare Policy & Benefit Services Division

CO-1311 (Rev. 9/2018)

EMPLOYEE INFORMATION

Employee Name (last, first, middle initial)	**Employee Number**	**Job Record Number**
Street Address	**Office Telephone No.**	**Social Security Number (must be provided)**
City, State, Zip Code	**Home Telephone No.**	_____ / _____ / _____
Employee Personal Email		

DEPENDENT INFORMATION (Individuals for whom expenses are claimed)

Relationship	Name (First, Middle Initial, Last)	Social Security No.	Sex	Date of Birth Month Day Year
		/ /		/ /
		/ /		/ /
		/ /		/ /

INSTRUCTIONS

Claim Submission Instructions

1. Attach proof of expense(s) incurred to this form.
2. Make copies for your records.
3. Note: Unless a change has occurred, SSN, address, daytime phone number and email address need only be provided at initial claim submission thereafter name & employee number is sufficient.

CLAIM REIMBURSEMENT INFORMATION

DATES OF SERVICE FROM	DATES OF SERVICE TO	DCAP Provider Name	DCAP Provider Address	Provider Tax ID/SSN	CLAIM AMOUNT
/ /	/ /				$
/ /	/ /				$
/ /	/ /				$
/ /	/ /				$
				Total	$

CERTIFICATION

I certify that pursuant to Internal Revenue Code Section 129, the expenses for reimbursement requested from my account were incurred by me and are for the dependent(s) covered by my DCAP.

I certify that pursuant to IRS regulations, the expenses were not reimbursed by any other plan and to the best of my knowledge and belief are eligible for reimbursement under my DCAP Flexible Spending Account.

I certify that the claim submitted is only for reimbursement of my dependent care expenses and that the dependent care services were actually incurred during the plan year.

I certify that I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

I understand that any amounts remaining in my DCAP account that have not been used for eligible expenses incurred during the plan year (January 1 - December 31) must be claimed for reimbursement no later than March 31 of the following year. After that date all remaining funds will be forfeited in accordance with current plan provisions and Internal Revenue Code requirements.

Employee Signature	**Date**

MAIL OR FAX COMPLETED FORM TO:

Progressive Benefit Solutions, LLC (PBS),
14 Business Park Drive #8, Branford, CT 06405
Phone 1-866-906-8023 or 203-985-1712
FAX: 203-974-4890