MERITAIN® HEALTH
An Aetna Company

Mail completed form to:	**Meritain Health P.O. Box 30111 Lansing, MI 48909**
Fax to:	**888.837.3725**
Customer Service:	**800.566.9305**

DEPENDENT CARE REIMBURSEMENT REQUEST FORM

Employer Name: **Citizens Memorial Hospital**

Employee Name:_____ SS# or ID#:_____

Address:_____ Telephone #:_____

City:_____ State:_____ Zip:_____ Is this a change of address? ❑ Y or ❑ N

Dependent Care Account (DCA)

Name of Day Care Provider	Dates of Service		Dependent's Name	Date of Birth	Amount of Expense
	From	To			
					$
					$
					$
					$
					$
			Total amount requested from your **DCA**:		$

Provider Signature:_____ **Provider SSN# or Tax ID:**_____

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

Please fill out all information completely. If more space is needed, list additional requests on a separate page. Please include all requests in the total. A minimum request amount (as established in your plan document) may need to be met before a claim can be paid. For further instructions, see the Guidelines for Reimbursement *below.*

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provision.

Employee Signature:_____ **Date:**_____

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, and sign and date the form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Dependent Care Reimbursement Account

- Expenses submitted must have been incurred for the care of a "qualifying individual" for the purpose to be gainfully employed.
- A qualifying individual is (i) a dependent of yours under age 13, (ii) a dependent of yours (or your spouse) who is incapable of caring for himself/herself.