HealthPartners®

Dependent Care Expense Claim Form

Employee Information — Please print clearly or complete form online

Last Name	First Name	Middle Initial
Doe	John	J

Social Security Number: 123-456-7890

Employer Name	Employee ID # (if applicable)
UnityPoint Health	12345

Email Address (if you would like an email confirming this claim has been received): john.doe@unitypoint.org

For address changes, please contact your Human Resources department.

Dependent Care Expenses (Please print)

Date(s) service was incurred From	Through	Full name of dependent receiving service	Relationship to employee	Age(s)	Amount requested for reimbursement
11/01/2012	11/30/2012	Johnnie Jr.	son	2	$113.25
11/01/2012	11/30/2012	Susie	daughter	2	$58.50
					$
					$
				Total Reimbursement Requested	**$**171.75

Provider Information

If supporting documentation isn't submitted, then this section will need to be completed by the provider of dependent care services each time a form is submitted.

Provider Name	Tax I.D. # or Social Security #
Generic Daycare Co.	55-5555555

Provider Signature	Date
	11/30/2012

Employee Certification

I hereby certify that the above information is correct; I have not received reimbursement previously for these expenses from any other plan; the total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000. I have read the printed materials I have received describing this plan; I will retain a copy of this form and all original receipts for my records; and I am responsible for compliance with all applicable administrative processes; tax regulations and documentation. I understand that it is my responsibility to return any duplicate reimbursement received from any other sources to my account; I am responsible for any and all bank, savings or checking account charges that I incur; and that expenses reimbursed through this account cannot be used as a deduction on my personal income tax return. I understand that if I have received an overpayment HPAI reserves the right to offset future reimbursements until repayment has been made.

Employee Signature _____ Date _____

To send online, log on to your *my*HealthPartners account at **healthpartners.com** to get started.

Fax to: 952-883-5026 or 877-624-2287

Mail to: HealthPartners Service Center, CDHP - Mail Route 21104T, P.O. Box 297, Minneapolis, MN 55440-0297

Questions: Metro Area: 952-883-7000 Outside metro: 866-443-9352
TTY line: 952-883-5127 **healthpartners.com**

Please retain a copy of this form and all attachments for your records.

Generic Daycare Co.

ABC123

Account Activity (October – present)

John J Doe
123 Walnut St
Minneapolis MN 55403

Generic Daycare Co
456 Oak St
Minneapolis MN 55401
Tax ID: 55-5555555

Students: Johnnie Doe (Jr), Susie Doe

Post Date	Student	Description	Charges	Payments	Balance	Service Dates
		Incoming Balance			$279.90	
10/15/12	Johnnie (Jr)	12-13 After E - Normal	$113.25		$404.30	11/01/12 – 11/30/12
10/15/12	Susie	12-13 After E - Normal	$58.50		$497.60	11/01/12 – 11/30/12
Total for Date Range			**$171.75**	**$0.00**		

HealthPartners Example of Claims Documentation