DEPENDENT CARE SPENDING ACCOUNT CLAIM FORM

EMPLOYEE INFORMATION *(to be completed by employee)*

GROUP NO.	EMPLOYER'S NAME	
EMPLOYEE'S NAME		MEMBER ID NUMBER
EMPLOYEE'S ADDRESS (Number & Street)*		*IS THIS A NEW MAILING ADDRESS? ( ) YES ( ) NO
(City, State, Zip)		EMPLOYEE'S DATE OF BIRTH
DAYTIME PHONE NUMBER (please include Area Code) ( ) -	FAX NUMBER (please include Area Code) ( ) -	EMPLOYEE'S E-MAIL ADDRESS

DEPENDENT INFORMATION *(to be completed by employee)*

NAME(s) OF DEPENDENT(s)	DATE(s) OF BIRTH	RELATIONSHIP TO EMPLOYEE

DEPENDENT CARE SPENDING ACCOUNT REIMBURSEMENT REQUEST *(to be completed by employee)*

Amount Requested from my Dependent Care Account: **$ _____._____**

Services rendered for the period beginning: _____ (mo/day/yr) thru _____. (mo/day/yr)

I certify that I have incurred the expenses for which reimbursement is claimed from my Dependent Care Spending Account and I further declare that I have not and will not claim credit for these expenses on my individual income tax return or any other employer sponsored dependent care program. I further certify that I have read and understand the Eligibility Requirements for reimbursement of Dependent Care expenses on the reverse side of this form and that I am eligible to receive benefits under this program.

Signature _____ Date _____

PROVIDER INFORMATION **(Complete this section if your day care provider does not provide receipts for payment.)**

PROVIDER NAME	PROVIDER I.D. NUMBER	PROVIDER'S SIGNATURE

Send this form, along with supporting documentation* to:
(Be sure to keep copies for your records.)

BCBSGA
Flexible Benefits Department
P.O. Box 4463
Chicago, IL 60680-4463

* ***Supporting documentation of proof of payment must be provided.*** *All expenses must be substantiated by a written statement from the provider, including the date the expense was incurred, the amount of the expense and the provider's tax I.D. or social security number. Canceled checks* ***are not*** *acceptable forms of documentation.*

If you have questions regarding your Dependent Care Spending Account,

you may call the Flexible Benefits Department at (800) 844-2946.