benepass

Dependent Care FSA Claim Attestation

Employee Instructions

Please use this form to accompany your dependent care claim if you are enrolled in a Dependent Care FSA and your dependent care provider does not provide receipts.

You may use your Benepass card to pay directly for dependent care services (and attach this completed form as your receipt), or you may submit this form in lieu of a receipt for reimbursement.

Care Provider Details

Please provide details regarding your dependent care provider. All fields must be completed.

Employee Name:	
Dependent Name(s):	Dependent(s) Date of Birth:
Period covered (MM/DD/YY - MM/DD/YY)	Amount incurred:
Care provider name	
Care provider address	
Care provider taxpayer identification number (or SSN)	
Care provider signature	

Attestation

To the best of my knowledge, the provided information is complete and accurate. I certify that my dependent care expenses are eligible as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that my employer and Benepass, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have either obtained or made reasonable efforts to obtain the provider's Tax ID (TIN). I should retain a copy of all submitted documentation in the event of an IRS audit.

Employee Signature	Date