

**MAIL CLAIM FORM TO:**

UnitedHealthcare  
PO Box 981178  
El Paso, TX 79998-1178  
Fax: (915) 781-1085 Phone: (877) 311-7849



**DEPENDENT CARE ASSISTANCE PLAN (DCAP) CLAIM FORM**

*Please complete the information on the other side of this page and review the following reminders to ensure accurate and timely processing of your request:*

- √ Is your Participant ID number included on the form?
- √ Is your Employer Name and DCAP Group Number included on the form?  
(You can find Dependent Care Assistance Plan Group Number printed on your Explanation of Benefits (EOB's) or Plan documents)
- √ Is your Total requested amount included on the form?  
(Requested reimbursements should be accumulated and submitted only after they total the minimum dollar amount specified by your plan)
- √ Did you attach copies of your itemized documentation with your request?
- √ Did you sign and date the bottom of this form?
- √ Have you made copies of your request for your own personal records?

The following examples are eligible for reimbursement through the Dependent Care Assistance Plan:

- Care for a dependent under the age of thirteen or a qualified individual incapable of self-care
- Licensed nursery schools
- Baby-sitters inside or outside the home while you (and your spouse) are at work. (As long as the individual is not your child and under the age of 19, or anyone you or your spouse can claim as a dependent for federal income tax purposes)
- Adult day care facilities
- After school programs
- Qualified child care centers

The following examples are ineligible for reimbursement through the Dependent Care Assistance Plan:

- Sleep away overnight camps
- Tuition fees for private or boarding homes
- 24-hour nursing home care
- Weekend or evening baby-sitting that is not necessary for you (and your spouse) to work
- Care provided for your child by a sibling under the age of 19 or someone you claim as a dependent on your income tax return
- Expenses for which you claim a tax credit on your federal income tax return

The above are some examples for eligible/ineligible expenses that can currently be reimbursed through the Dependent Care Assistance Plan.

If you have any expenses that are in question, please feel free to contact a representative at (877) 311-7849.

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**Please Read These Instructions Before Completing The Dependent Care Assistance Plan  
Withdrawal Request**

1. Employee must complete **Part 1** and **Part 2** "Dependent Care Expenses".
2. Instructions for **Part 2**:  
Attach a **copy** of a receipt that includes the dates of service, day care provider's name, and amount paid to day care provider or attach a **copy** of a cancelled check from the day care provider.
3. Read the Certification For Reimbursement, **sign and date the form**. Make a **copy** for your records.
4. Mail (or fax) the form to the address (or fax number) provided on this form. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.

**PART 1 EMPLOYEE INFORMATION** (Please Print)

EMPLOYEE NAME (Last and First)	PARTICIPANT ID	DATE OF BIRTH / /	DAYTIME TELEPHONE NO. ( ) -
EMPLOYEE ADDRESS		DCA GROUP NUMBER	EMPLOYER NAME

**PART 2 DEPENDENT CARE EXPENSES** (Please Print) Please place each expense on a separate line

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICE(S)	REQUEST AMOUNT
		From:	To:		
		From:	To:		
		From:	To:		
		From:	To:		
		From:	To:		
		From:	To:		
<b>DEPENDENT CARE EXPENSES SUBTOTAL</b>					\$

**CERTIFICATION FOR REIMBURSEMENT**

I certify that the expenses for reimbursement requested from my Dependent Care Assistance Plan were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Dependent Care Assistance Plan. I (or/we) will not use the expenses reimbursed through the Dependent Care Assistance Plan as deductions or credits when filing my (our) income tax return.

**EMPLOYEE SIGNATURE:**

**DATE:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**