BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
www.bbpadmin.com
630 773 2337

Submit your claim online
Claim Submittal Options
or Mail, Fax, or Email Completed Form to:

BBP Admin
125 West Orchard Street - Itasca, Illinois 60143-1764
Phone (630) 773-2337– Fax (630) 775-8568 – E-mail claims@bbpadmin.com

Employer Name: _____

20___ DCAP REIMBURSEMENT REQUEST FORM

Employee Name: _____

Daytime Phone # or E-Mail Address: _____

☐ Please check this box if your address on file with BBP has changed. **New Home Address**_____

Instructions: Complete the information below for Dependent Care Expenses incurred by you or your Spouse for which you request reimbursement. (For information as to what Dependent Care Expenses can be reimbursed, see the Salary Reduction Plan Summary Plan Description.) You must provide bills, receipts, or other evidence from your dependent care provider or other evidence that the Expenses were incurred (no canceled checks). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you. **Please date and sign the Form then send it along with your supporting documentation to BBP at claims@bbpadmin.com or 630-775-8568 or 125 West Orchard St. – Itasca, IL, 60143-1764.**

	Example	Expense #1	Expense #2	Expense #3	Expense #4
Date(s) dependent care service was actually provided	03/01/2020 to 03/31/2020	_____ to _____	_____ to _____	_____ to _____	_____ to _____
Name & age of dependent	Fred Jones Age 4				
Name, Employer Identification Number (Social Security number for an individual), and address of service provider	Sue Smith 376-13-7753 123 Day St. Chicago, IL 60606				
Proof of expense attached?	☐ YES ☐ NO				
Reimbursement requested	$250				

☐ **This is a recurring claim for the current plan year – please enter for the entire plan year. If my recurring charge changes, I will notify BBP.**

TOTAL REIMBURSEMENT REQUESTED $_____

I authorize the above expenses to be reimbursed from my DCAP Account. To the best of my knowledge, my statements in this form are true and complete. I certify all of the following: My family member has received the services described above on the dates indicated, and the expenses qualify as valid Dependent Care Expenses as defined in the Salary Reduction Plan document ("the Plan"). The expenses listed are for a Qualifying Individual as defined in the Plan. These expenses have not previously been reimbursed under the DCAP or any other plan, and I will not seek reimbursement for them under insurance or any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Tax Credit). I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification numbers. I also understand that any reimbursement I receive for these expenses cannot be excluded from my income to the extent that the reimbursement, when added to excludable reimbursements to date for Dependent Care Expenses incurred during the same calendar year (from any plan), exceeds the statutory limits described in the Salary Reduction Summary Plan Description. I have read, understand, and make the certifications contained in the Certificate of Qualifying Dependent Care Expenses on the reverse side of this Form.

Employee Signature:_____ Date:_____

Claim Confirmation: You can easily view your claim status 24 hours a day by checking BBP's website at betterbusinessplanning.wealthcareportal.com Please allow 72 business hours for processing of your claims.

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