Request for reimbursement

Employee Signature:____





DCAP Claim Form Township of Ocean Board of Education Employee Last Name (Please Print)________Middle Initial ______ ______State_____Zip_____ Address___ ______Home Phone (____) ________Work Phone (____) _____ Social Security Number____ Employee E-mail Address (if any)____ Be sure to provide all information requested in each row as outlined in the 1st row, which is an example. If the form is incomplete, it will be returned to you. You can send this form along with the third-party documentation substantiating your claim(s) to OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, or by email at claims@oca125.com, or fax directly to 609-514-0111, 609-514-2778 (Alternate), 609-570-8980 (Alternate). Dependent Care Claims Amount Age Provider Name **Service Description** Provider Tax ID#/SS# Dependent Name Service Period (DCAP) From 123456789 02/01/16 02/28/16 11 ABC Day Care **DCAP** \$100 John Smith \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ Provider's Certification (If the provider signature certification is provided, employees are not required to submit supporting documentation): I certify that I am the above mentioned provider or an authorized representative of the above mentioned provider. I further certify that the services specifically described above were provided by the provider for the above named dependent during the service period specifically described above. NOTE: Do not complete this section if you are not the above mentioned provider or the services described above were not provided (or the participant has not completed the section above). Provider Name_____ Provider Signature: _____ Employee's Certification: I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependent(s), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.