State of Connecticut

Dependent Care Assistance Program
Claim Reimbursement Form
Revised 09/09

MAIL OR FAX COMPLETED FORM TO:
Progressive Benefit Solutions, LLC (PBS)
23 Maiden Lane
North Haven, CT 06473
FAX: (203) 985-1717
Phone: 1-866-906-8023

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	DATE OF BIRTH

HOME ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE NO.
(☐ Check if new address)		

Attach valid receipts for each dependent care expense.

DATES OF SERVICE FROM	TO	Dependent Name & Relationship	DOB	DCAP Provider Name	DCAP Provider Address	Provider Tax ID/SSN	CLAIM AMOUNT
							$
							$
							$
							$
							$
						TOTAL:	$

I certify that the expenses for reimbursement requested from my account were incurred by me and are for the person covered under the DCAP, the expenses were not reimbursed by any other plan and to the best of my knowledge and belief are eligible for reimbursement under my Flexible Spending Account Program.

I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

Employee Signature ____ **Date** ____________________

Claim Submission Substantiation:

1. Attach proof of expense incurred to this form
2. Make copies for your records
3. Note: SSN, DOB, address & home number need only be provided at initial claim submission thereafter name & employee number is sufficient