Dependent Care Account Claim Form

Kazdon, Inc.
Payroll • Benefits • FSA

Instructions For Quick Claim Processing:

- Complete ALL account holder information. Please give your employer name "**without**" abbreviation.
- Use your documentation to complete each section of the form, including the following items:
  - Provider Name
  - Service Dates
  - Dependent Name and Relationship to Account Holder
  - Type of Service
  - Amount Billed
  - Provider Signature: *Is not required but can replace need for other proof of service*
- Fully complete & sign this claim form

- **File claim online:** Join the growing majority of participants who submit their claims online for faster service. Log into your account at www.kaznection.com to file your claim electronically, upload your documentation and view your account balance.
- **Claim processing time:** Please allow 2 business days for claims to be processed.

1. Personal Information

Company Name: | Employee Phone Number:

Employee Name: First Name, Last Name, MI | Social Security Number: (Required)

Employee Street Address, City, State, Zip: | Address Change? ☐ Yes ☐ No

2. Dependent Care Expenses: *Dates of Service are required in order to process claim*

Service Dates MM DD YY to MM DD YY	Dependent Name	Age	Amount
___ ___ ___ to ___ ___ ___			$

Relationship to Account Holder: ☐ Spouse ☐ Qualifying Relative ☐ Qualifying Child ☐ Other:

Type of Service: ☐ Child Care ☐ Senior Day Care ☐ Preschool ☐ Before/After School ☐ Summer Day Camp

Provider Name: (Print) | Provider Tax ID # or SSN #: | Provider Signature:

Service Dates MM DD YY to MM DD YY	Dependent Name	Age	Amount
___ ___ ___ to ___ ___ ___			$

Relationship to Account Holder: ☐ Spouse ☐ Qualifying Relative ☐ Qualifying Child ☐ Other:

Type of Service: ☐ Child Care ☐ Senior Day Care ☐ Preschool ☐ Before/After School ☐ Summer Day Camp

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Type of Service: ☐ Child Care ☐ Senior Day Care ☐ Preschool ☐ Before/After School ☐ Summer Day Camp

Provider Name: (Print) | Provider Tax ID # or SSN #: | Provider Signature:

Total Dependent Claim $ 0.00

I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and/or mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and I confirm that, by requesting reimbursement here, that I have not and will not seek reimbursement of this expense from any other plan or party.

Employee Signature _____ Date _____

Please Fax or Mail your claim form and receipts to the following:

Mail: Kazdon, Inc., P.O. Box 29927, Austin, Texas 78755

Fax: (512) 340-0406