Dependent Care Account Reimbursement Request Form

Lifetime Benefit Solutions

Employer name: _____

Participant name (First, MI, Last): _____

Social security number: _____

Address: _____

City, ST, Zip: _____

Date of birth: _____ Phone number: _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Please complete either Option A or Option B

Option A: If your dependent care provider provides you a receipt, please complete this section and attach a copy of the receipt.

Claimant Name	Date of care start date (within a single plan year)	Date of care end date (within a single plan year)	Provider	Amount	Claim Ref #
John Sample	*1/1/2026*	*12/31/2026*	*ABC*	*$150.00*	*Example*
					01
					02
					03
					04

Option B: If your dependent care provider does not provide you with a receipt, please have the provider complete and sign this section.

Provider name: _____

Address: _____

City, ST, Zip: _____

Tax payer ID/SSN: _____

Dependent care for (name and age): _____

Dates of care (within a single plan year) Start date: _____ End date: _____

Amount charged: $_____

Provider signature: _____ Date: _____

Participant Authorization

By submitting this form to Lifetime Benefit Solutions, I certify that the information here is true and correct.

- I authorize the above expenses to be reimbursed from my dependent care account.
- I certify the expenses qualify as valid dependent care expenses under the terms of the Plan.
- I understand that the copy of my receipt will include Provider name, address, tax ID/SSN, child's name and age, dates of care, and amount charged.
- I will keep copies of all documents submitted to Lifetime Benefit Solutions for my own personal records.
- I understand a qualifying dependent is a child under age 13, who is claimed as a dependent on my federal income tax return (special rules apply for divorced parents), a disabled spouse, and any other dependent on my tax return who resides in my home and is physically or mentally disabled.
- I certify these expenses have not previously been reimbursed and I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit.
- I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification number.

Submission options

(choose only one)

Online: Login to your consumer portal

Mail: Lifetime Benefit Solutions Claims Dept.
PO Box 211126
Eagan, MN 55121

Fax: (877) 256-7228

Should you have any questions, please contact our Customer Service Team at (800) 327-7130

Lifetime Benefit Solutions