# RECURRING DEPENDENT CARE REIMBURSEMENT REQUEST

| | |
|---|---|
| Employer Name: | Start Date of Automatic Daycare Reimbursement: |
| Plan Year: | |

**Employee Information**

| | |
|---|---|
| Employee Name: | Last 4 of Social Security #: |
| Email Address: | Phone #: |

**Dependent Information**

| Name | Gender | Date of Birth |
|---|---|---|
| Dependent: | | |
| Dependent: | | |
| Dependent: | | |
| Dependent: | | |

**Care Provider Information**

| | |
|---|---|
| Care Provider Name: | Start Date of Service: |
| Care Provider Social Security/Tax ID #: | End Date of Service: |

Dear Dependent Care Provider:

The participant named above is enrolled in an employer sponsored Dependent Care Flexible Spending Account. Through this Pre-tax Account, dependent care expenses are deducted from his/her paycheck on a pre-tax basis and may be requested to reimburse eligible dependent care expenses incurred.

This participant has requested regularly scheduled payments each month for reimbursement of dependent care services based on their employer's payroll cycle. The IRS requires that proof of services (a receipt) be provided by you, the care provider. Rather than submitting a claim and receipts each month, this form will allow reimbursements to be sent to the participant every month, automatically.

Please complete the Care Provider information and sign below to allow automatic reimbursement for this participant.

**I have read the above and understand and verify that the participant listed receives dependent care services, for which he/she regularly pays no less than $_____per week.**

**Dependent Care Provider Signature _____ Date _____**

**Employee Acknowledgement of Automatic Dependent Care Request Terms**
Please initial next to each line item to indicate you acknowledge the terms of this automatic dependent care request.

_____ I understand if Dependent Care services cease or decrease from the amount stated above it is my responsibility to inform TASC in a timely manner of the change.

Submit completed form to:
Claims: claims@tasconline.com I toll-free fax 866-450-1480 I TASC I P.O. Box 7213 I Madison, WI 53707-7213
Service: svchelp@tasconline.com I toll-free 866-678-8322

_____ I understand that I will need to complete a new form should the weekly cost for my Dependent Care services change from the amount indicated on this form.

_____I understand if I leave employment, any payments received in excess of the amount of payroll deductions taken will be considered "overpayments" as described in the official plan document, and I will be required to repay those funds.

_____I understand that I am required to have direct deposit set up with TASC to receive claim reimbursements.

**EMPLOYEE CERTIFICATION OF RECURRING EXPENSES AND CLAIMS FOR REIMBURSEMENT**

**Employee Signature: _____ Date: _____**

Check the status of your claim online at https://MyBenefitsPortal.TASConline.com.

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# DIRECT DEPOSIT AUTHORIZATION

I hereby authorize TASC to initiate deposit of my medical and/or dependent care expense reimbursements to the bank account indicated below and, if necessary, debit entries and adjustments for any credit entries made in error to my account.

***Please attach a copy of a voided check if you are electing to have reimbursement sent to a checking account.***

***If you are electing to use your savings account please contact your bank for the Transit ABA Routing Number.***
If you are re-enrolling during Open Enrollment and are already signed up for direct deposit, you do not have to complete this form. We will continue to deposit reimbursements to the bank account on record.

This account is (Please check one of the following options)

New_____ Change_____ Cancel_____ Name of Bank: _____

| _____ | _____ | _____ |
|---|---|---|
| Transit ABA Routing Number | Account Number | Account Type (Checking or Savings*) |

**Attach Voided Check OR Savings Deposit Slip HERE**

Bobby Brady **3448**
123 Main Street 7-1-945
Anywhere, USA 55439 Date _____

*Pay to the Order of* _____ ☐

_____*Dollars*

For _____ _____

⑆091000019⑆ 356489589⑈ 3448

(Routing Number) (Account Number)

**Employer Name:** _____ ❑ **Address Change**

**Employee Name:** _____ **Last 4 of SSN:** _____

**Home Address:** _____

_____

**Email Address:** _____ **Telephone:** _____

_____ _____
Signature Date

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