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Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when you want to receive recurring reimbursement of dependent care expenses. Documentation must be retained for your records and provided to Discovery Benefits when requested to do so (if a receipt is unavailable, a signature from the provider is sufficient). If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

* = Required Fields

Step 1: Participant Information

*Participant Name (First, MI, Last)

*Social Security Number ___ - __ - ____

*Employer Name (Do not abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at www.DiscoveryBenefits.com.

Step 2: Recurring Dependent Care FSA Information

*Please select only one:

☐ **Start Recurring Dependent Care FSA:** Please start my recurring reimbursement with the information provided in Step 3.

☐ **Change Recurring Dependent Care FSA Information:** Please update my recurring reimbursement with the information provided in Step 3 as of the Effective Date listed on the right.

☐ **Stop Recurring Dependent Care FSA:** Please stop my recurring reimbursement for the information provided in Step 3 as of the Effective Date listed on the right.

Effective Date (mm/dd/yyyy)

Step 3: Dependent Care Provider Information and Signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

*Dependent(s) Name	*Start Date of Service Must be within current plan year (mm/dd/yyyy)	*End Date of Service Must be within current plan year (mm/dd/yyyy)	*Provider's Signature	*Cost Per Week	*Total Cost

Step 4: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. By submitting this, I acknowledge my child is under the age of 13, the services are eligible dependent care expenses as defined by the IRS, that I have not been previously reimbursed for these expenses and that I will not seek reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. I understand that Discovery Benefits may require me to submit any additional documentation, receipts and an updated request form at any time. I should retain a copy of all submitted documentation in the event of an IRS audit. I confirm my payroll deductions are less than my daycare costs per week so recurring reimbursements will occur when payroll deductions post to my Dependent Care FSA. By submitting this form I certify the above.

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