

Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when the participant wants to receive recurring reimbursement of dependent care expenses. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to Discovery Benefits when requested to do so. 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

<input type="text"/>	<input type="text"/>
*Employer Name (Do not abbreviate)	*Employee ID
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
*Participant Name (First, MI, Last)	*Social Security Number

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

Step 2: Recurring Dependent Care Account (DCA) Information

*Please select only one.

	Effective Date (mm/dd/yyyy)
Start Recurring DCA: Please start my recurring reimbursement with the provided information effective the date specified.	
Change Recurring DCA Information: Please update my recurring reimbursement with the provided information effective the date specified.	
Stop Recurring DCA: Please stop my recurring reimbursement with the provided information effective the date specified.	

*Dependent(s) Name	*Date of Birth (mm/dd/yyyy)	*Start Date of Service (Must be within current plan year)	*End Date of Service (Must be within current plan year)

Should the cost of day care per month meet or exceed the monthly payroll deduction, reimbursements will be made as payroll deductions post to your Dependent Care Account. If the monthly cost of day care is less than the monthly payroll deductions, reimbursement will be made once per month at the end of the month.

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 eliminate the necessity for the participant to provide receipts for reimbursement purposes. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

<input type="text"/>	\$ <input type="text"/> per month/week	<input type="text"/>
*Provider's Name	*Cost per month/week (circle one)	*Provider's Signature
<input type="text"/>	\$ <input type="text"/> per month/week	<input type="text"/>
*Provider's Name	*Cost per month/week (circle one)	*Provider's Signature

Step 4: Participant Certification

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking 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 documentation is required as proof of incurred claims and that I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form I certify the above.

