Recurring Dependent Care Request Form

46770438 (12/18)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Enrollment may be delayed if fields with an asterisk are not filled out.

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 BenefitHelp Solutions upon request. Receipts can be uploaded through the participant portal or faxed to 855-778-9837. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

Section 1 Consumer Information

* Consumer first name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* SSN or BHS identification number
* Mailing address		* City	* State	* ZIP
* Physical address		* City	* State	* ZIP
* Email address			* Contact phone number	
* Employer				

Section 2 Auto-Dependent Care (DCA) information

2a) Recurrence status

Please select only **one to start, change, or stop reimbursement.*

☐	**Start recurring DCA:** Please begin recurring reimbursement of my dependent care expenses. I understand BenefitHelp Solutions will request receipts as proof that expenses have been incurred.	**Effective date (mm/dd/yyyy)**
☐	**Change recurring DCA information:** Please update my recurring reimbursement information with the provided information effective by the date specified in box A.	**A.** _____ / _____ / _____
☐	**Stop recurring DCA:** Please stop recurring reimbursement of my dependent care expenses effective by the date specified in box B.	**B.** _____ / _____ / _____

2b) Dependent's information

*Dependent(s) name(s)	* Dependent's Social Security Number	* Dependent's 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)	* Service type (choose One)
		_____ / _____ / _____			☐ Child care ☐ Adult care**
		_____ / _____ / _____			☐ Child care ☐ Adult care**

**If choosing Adult Care as the Service Type, you must provide a letter from a doctor or a Medical Necessity Form that identifies that the dependent is physically or mentally disabled and unable to self-care.

Return the completed form to BenefitHelp Solutions

Mail: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108 **Fax:** 855-778-9837

Questions? Contact BenefitHelp Solutions at 855-378-0197, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

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Section 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.

* Provider's name	Cost per month/week (circle one) $_____ per month/week	* Provider's signature
* Provider's name	Cost per month/week (circle one) $_____ per month/week	* Provider's signature

Section 4 Participant Certification

To the best of my knowledge, the information provided 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 BenefitHelp Solutions including its agents and employees, will 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 BenefitHelp Solutions. I understand that it's my responsibility to retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form, I certify the above.

* Participant signature	* Date

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