Automatic Dependent Care Request Form

Discovery Benefits
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This form is to be completed each plan year the participant wants to receive automatic reimbursement of dependent care expenses. Should the cost of daycare 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 daycare is less than the monthly payroll deductions, reimbursement will be made once per month at the end of the month.

*=Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

*Employee ID

*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: Auto Dependent Care Account (DCA) Information

**Please select only one. If changing or stopping*

	Start Auto DCA: Please begin automatic reimbursement of my dependent care expenses	**Effective Date** *(mm/dd/yyyy)*
	Change Auto DCA Information: Please update my automatic reimbursement information with the provided information effective by the date specified in box A.	
	Stop Auto DCA: Please stop automatic reimbursement of my dependent care expenses effective by the date specified in box A.	

***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)*

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.

*Provider's Name

$ per month/week
*Cost per month/week (circle one)

*Provider's Signature

*Provider's Name

$ per month/week
*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 I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form I certify the above.