

Form Completion Guide

STEP 1: Participant Information

- Please write legibly. Missing information may delay the processing of your claim.
- **This form will need to be filled out each plan year that you choose Automatic Dependent Care.**
- Dependents and Date of Birth: Please fill in the information for eligible dependents receiving childcare services
- Start Date and End Date: Start date is the first date that services begin and End date is the last day services end. Make sure that these dates are within your plan year.
- Childcare Expenses per Plan Year: List childcare expenses for each child for the Plan Year.
- Payroll Contribution: Please list the dollar amount that will be coming out of your check on a pre-taxed basis for dependent care per payroll.
- Payroll Frequency: Enter the number of payrolls for the current plan year
- **Please stop auto DCA:** Checking this box will stop your auto dependent care. Also, please list the first payroll date affected by this change.
- **Please change auto DCA information:** Check this box if you have changes to your dependent care account such as change in number of dependents, increase or decrease in expenses, change in daycare provider or dates of service changed.
- **If there are any changes in the information provided, it is the participants' responsibility to notify Discovery Benefits in a timely manner.**

STEP 2: Reimbursement Information

Please have your dependent care provider fill out and sign step 2.

If you have children with different Daycare Providers, please complete a separate form for each child.

STEP 3: Participant Certification

Sign and date the form after reading the Participant Certification. Your signature is required for reimbursement.

Form Submission Guide

Determine the method that you prefer to submit your auto request

1. Fax toll free to 1-866-451-3245
2. Mail to PO Box 2926, Fargo, ND 58108-2926

Discovery Benefits will process your claim promptly (two business days from receipt). If there are any concerns about your claim, you will be notified in writing.

Would you like to receive your refund via free direct deposit?

Direct deposit enrollment forms can be found on online at discoverybenefits.com

Automatic Dependent Care Request Form



STEP 1 - Participant Information -- Missing information may delay the processing of your reimbursement.

Name Employer

Social Security Number Employee ID #

Dependent(s) Name	Date of Birth	Start Date of Service	End Date of Service	Childcare Expenses Per Plan Year	Payroll Contribution	Payroll Frequency

Service end date must be equal to or less than the end of your flex plan year end date.

STEP 1A - For Changes ONLY, please fill out 1A.

- Please Stop Auto DCA
First payroll date affected by change _____
- Please Change Auto DCA Information
First payroll date affected by change _____

STEP 2 - Dependent Care Provider Information (to be completed by Dependent Care Provider)

Please complete the dependent care provider information and sign below to allow automatic reimbursement for this participant.

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 pay period 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. Instead of submitting a receipt each month for reimbursement, this form will allow reimbursements to be sent to the participant every month, automatically.

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 _____. (i.e. week/month)

Dependent Care Provider's Name	Provider's Tax ID number or SSN (Required by IRS and reported on IRS Form 2441)	Dependent Care Provider's Address

Daycare expenses less than payroll contributions will be reimbursed **Monthly**

Dependent Care Provider Signature _____ **Date** _____

STEP 3 - Participant Certification: To the best of my knowledge and belief, my statements on this form are complete and true. I certify that the requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other source. I also understand that Discovery Benefits, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I authorize a deduction in my account in the amount of the reimbursement. I have received or will receive the services described above and the expenses are my out-of-pocket expenses that qualify as valid expenses under the Plan. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include that TIN on IRS Form 2441 that I must attach to my federal income tax return. If there are any changes in the information noted above, it is my responsibility to notify Discovery Benefits. Please retain a copy of all documentation for your records in the event of an IRS audit.

Participant Signature _____ **Date** _____

Auto Claim Submission Only