Flexible Spending Accounts
Phone: 1-877-747-4141
Fax: 1-866-593-7125

Recurring Dependent Care Contract & Claim Form

Personal Information: (Please Print)

Employer's Name	**Date of Reimbursement Request**
Employee's Name	**Email Address**
Employee's Social Security Number	**Daytime Telephone Number**

Recurring Dependent Care Reimbursement Request Expense(s)

Dependent's Name	Relationship to Employee	Age	Date Range of Service (usually the plan year or provider contract term, whichever term is less*)	Total Requested Reimbursement
1)			to	
2)			to	
3)			to	
4)			to	
			Total	**$**

Dependent Care Provider Affidavit Information

Provider's Name:	**Provider's Tax ID or SSN:**
The cost of service is $	**Provider Rate/Contract Start Date:**
☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** Note: Hourly claims cannot be set-up as recurring.	**Provider Rate/Contract End Date:**

Dependent Care Provider: *Please read the following statement, sign and date:* ***I verify that the above charges are accurate as described.***

Provider's Signature *Date*

Employee Certification for Reimbursement Request

I hearby certify that:

* The above information is correct
* I have not received, nor will I seek reimbursement for the expenses listed above from any other plan, including through the use of my Continuon Services Master Card®.
* The above listed expenses are not eligible for reimbursement under any other plan.

I also understand that:

- Reimbursement is not a guarantee that this payment is tax free;
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return.
- I understand that reimbursements will be made only up to the cash balanace in my Dependent Care Account.
- I understand that unpaid claims are reimbursed as more money is credited to my account. Unused funds at the end of the plan year will be forfeited.

I verify that I make regular payments to the Dependent Care provider described above for the dependents named above. I authorize Continuon Services, LLC to automatically reimburse me the amount stated above from my Dependent Care Flexible Spending Account. I agree that if the amount changes or if, for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will notify Continuon Services, LLC immediately in writing. This form is valid for only the current plan year or until the contracted rate described above changes, whichever term is less*. I understand this form is not valid unless signed by my Dependent Care provider. I understand the right to submit claims via this program may be discontinued at any time. I understand that the rules and regulations that govern Flexible Spending Accounts are a matter of law and are strictly enforced by the Internal Revenue Service (IRS). I understand that hourly services cannot be set-up as recurring.

Employee Signature *Date*

If you have questions, please contact us at: 1-877-747-4141.

Submit to: Continuon Services, LLC
Attn: Flexible Spending Account Administration
P. O. Box 1379
Roswell, GA 30077-1379

or **Fax to: 1-866-593-7125**

** If the contracted rate with your provider changes, a new form must submitted. A new form must be submitted each plan year even if the contracted rate does not change.*