

Automatic Dependent Care Request Form

Please Print Clearly

PERSONAL INFORMATION

Company Name Social Security #

Employee Name Phone ()

Address _____ City _____ State _____ Zip Code _____

Please check if this is a new address

Email

Auto-Dependent Care (DCA) Information

This form is to be completed each plan year the participant wants to receive automatic reimbursement of dependent care expenses.

Start Auto-DCA Change Auto-DCA Information Stop Auto DCA

Effective Date _____

Dependent(s) Name & Date of Birth	Start Date of Service (Must be within current plan year)	End Date of Service (Must be within current plan year)

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.

Provider's Name, Tax ID, and Signature	Cost Per Month/Week (please circle one)	Total Amount Requested
	\$ monthly/weekly	\$
	\$ monthly/weekly	\$

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 The Employers Association, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to notify The Employers Association. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Participant Signature (**Void if not signed**)

Date Signed

Send your completed form to
The Employers Association
Attn: FSA Services
3020 West Arrowood Road Charlotte, NC 28273
Fax to: 704.944.6076
Email to: fsa@employersassoc.com