

Dependent Care Recurring Expense Form



Employee information

Employer name _____ PacificSource member ID _____
Employee last name _____ First name, MI _____
Mailing address _____
City _____ State _____ Zip _____
Home phone _____ Work phone _____ Email address _____

Dependent information

Dependent name _____ Date of birth _____
Dependent name _____ Date of birth _____
Dependent name _____ Date of birth _____
Dependent name _____ Date of birth _____

Daycare provider information (to be completed by daycare provider)

Daycare provider name _____ Provider Tax ID _____
Provider rate _____ Rate start date _____ Rate end date _____
Frequency:
Weekly Biweekly, on the following days of the month: ____ and ____ Monthly, on the ____ day of the month

Provider Signature _____ Date _____

Examples of eligible dependent care expenses: daycare centers, nanny services, day camps, preschool, before- and after-school care, elder care

Examples of ineligible dependent care expenses: meals, overnight camps, medical care, educational expenses / tuition, kindergarten, misc. fees (activity fees, field trips etc.)

Recurring claim authorization

This form eliminates the need for additional documentation for recurring dependent care expenses (DCE). **It is valid for the duration listed above, or the current plan year, whichever is less.** Please note: hourly rates cannot be set up as recurring expenses.

Please accept this form and register me for recurring reimbursement of day care expenses through my DCE account.

As payroll deductions are received, PSA will automatically generate reimbursement for expenses incurred. I understand I will need to complete a new DCE Recurring Expense Form **each plan year** or when my contract ends on the date shown above.

To the best of my knowledge, the statements in this Dependent Care Recurring Expense Form are complete and true. I am claiming reimbursement only for eligible expenses incurred for eligible plan participants during the applicable plan year. I certify that these expenses have not been, nor are they expected to be, reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my DCE flexible spending account to be reduced by the amount requested above.

Employee Signature* _____ Date _____

PO Box 2797, Portland, OR 97208-2797 | Phone 800-422-7038, TTY: 711. We accept all relay calls. | FAX 866-446-6090

Submit claims electronically through the PacificSource Administrators, Inc. FSA/HRA portal at: PacificSource.com/PSA