Dependent Care Recurring Expense Form

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FAX (866) 446-6090
Submit claims electronically through MyFlex at: PacificSource.com/Legacy

EMPLOYEE INFORMATION

LEGACY HEALTH
Employer name ______________________ Member ID number ______________________

Employee last name ______________________ First name ______________________ Middle initial ______________________

Home phone ______________________ Work phone ______________________ Email address ______________________

DEPENDENT INFORMATION

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 ______________________ Frequency: ☐ Weekly ☐ Biweekly ☐ Monthly Rate start date ______________________ Rate end date ______________________

Provider signature ______________________ Date ______________________

Examples of **Eligible** Dependent Care Expenses	Examples of ***Ineligible*** Dependent Care Expenses
• Daycare centers	• Meals
• Nanny services	• Overnight camps
• Day camps	• Medical care
• Preschool	• Educational expenses / tuition
• Before and after school care	• Kindergarten
• Elder care	• 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 (required) ______________________ Date ______________________