

**Automatic Dependent Care Request Form**

Dear Dependent Care Provider:

This participant named below has requested regularly scheduled payments each month 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 the care provider. Instead of submitting a receipt each month for reimbursement, this form will allow reimbursements to be sent to the participant every (week/month...), automatically.

**Provider Name:** \_\_\_\_\_

**Provider EIN/SSN:** \_\_\_\_\_

**Starting Date of Service:** \_\_\_\_\_

**Name(s) of Dependent(s) Needing Care:** \_\_\_\_\_

**Care Provider must agree to the following:**

I have read the above and understand and verify that the participant listed below receives dependent care services, for which he/she regularly pays no less than \$\_\_\_\_\_per week.

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Participant/Account Holder Information:**

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Last 4 of Social Security: \_\_\_\_\_

Start Date for Reimbursement: \_\_\_\_\_

Initial Next to the following statements to indicate you have read and agree:

\_\_\_\_\_ I understand that amounts may not be reimbursed until (1) payroll deposits have funded my dependent care account AND (2) dependent care expenses have actually occurred.

\_\_\_\_\_ If dependent care services cease or decrease from the amount stated on this form, I understand that it is my sole responsibility to inform TPA in a timely manner of the change

Participant Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**Return to:** MEDSURETY LLC  
4350 Baker Rd, Suite 350  
Minnetonka, MN 55343  
Email:  
[customerservice@medsurety.com](mailto:customerservice@medsurety.com)  
Fax: (952) 856-2656