MEDSURETY

Maximize Your Health Savings

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:

Account Holder Name: _____ Last 4 of SSN:_____

Employer: _____

Start Date for Reimbursement: _____

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

_____ I understand that must sign up for Direct Deposit of my funds in order to participate in this program. Check reimbursements will not be allowed.

_____ 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
18001 Highway 7, Suite 204
Minnetonka, MN 55345
Email: customerservice@medsurety.com
Fax: (952) 856-2656