the Taben Group Flex Administration in cooperation with Surency

TabenFlex
RECURRING DEPENDENT CARE REQUEST FORM

Employee Name ________________________________
(Last Name, First Name, MI (Please Print)

Employer Name ________________________________

Address ____
(Address, City, State, ZIP)

Employee ID ____________________________________
(Last four digits of social security number or Employee ID (EID) as appropriate)

Dependents for whom care will be provided by the same provider *(First and last name)*	**Date of Birth** *(mm/dd/yyyy)*

Dependent Care Provider Information (<u>to be completed by the provider only</u>)

Provider's Name ______________________________________ Tax ID No. __________________

The provider charges $ ________________________ ☐ Weekly ☐ Bi-weekly ☐ Monthly

☐ Other (please describe fees) ____

Rates are effective (start date) ______________________ to (end date) ________________________

By signing this, I certify that the information I provided above is accurate and I understand that the information is to substantiate the name of the dependent care provider, the dates of dependent care services rendered by the dependent care provider, and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

Provider's Signature (required) ____________________________________ Date ______________________

Important Information About Dependent Care Service Periods and Expense Reimbursement

The IRS has strict requirements for reimbursements for dependent care expenses. Dependent care expenses must be fully "incurred" prior to receiving reimbursement which means that <u>dependent care services must have been fully provided and completed for the service period before you are reimbursed for your dependent care expenses</u>. This is an important point to remember because most providers require prepayment of dependent care services at the beginning of the service period before they provide dependent care services. In order to follow IRS' requirements, you may only be reimbursed at the end of the service period even if you prepaid the provider for dependent care services. An example:

Jane has a young daughter, Amy, in daycare. Jane uses daycare services so she can work full-time Monday through Friday. She pays her daycare provider weekly on Mondays. When Jane takes Amy to daycare on Monday, January 2, she pays the provider for the week. The dependent care service period for which she is paying is Monday, January 2, through Friday, January 6. Jane is pre-paying for dependent care services because she pays on Monday, but the service period is not complete until Friday, January 6.

According to the IRS, Jane cannot receive reimbursement for this dependent care expense until January 7, after the full service period (January 2 - 6) has ended and all services have been provided in full. It is at this point that expenses are considered fully "incurred".

For additional information on Dependent Care reimbursements, please visit www.taben.com or call 855.826.8692.

.

Recurring Claim Authorization

This form eliminates the need for additional documentation for <u>recurring dependent care expenses in the same amount from the same provider for the same service period lengths</u>. Please note: Hourly or variable rates cannot be set up as recurring expenses. **I understand that I will need to promptly complete and submit a new request form if any of the provided information above changes**. <u>This form is valid for the rate duration listed above, or the current Plan Year, whichever is shorter.</u>

As payroll deductions are received, Taben will automatically generate reimbursements for recurring expenses after the date they are incurred as provided above.

To the best of my knowledge, the provided information above is complete and true. I am claiming reimbursement only for eligible expenses incurred for eligible plan participants during the applicable Plan Year. I certify that I have not been previously reimbursed for these expenses and that I will not seek reimbursement from any other source. I should retain a copy of all submitted documentation in the event of an IRS audit. I understand that Taben, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement or the provided information is not complete or true. I authorize my Dependent Care Flexible Spending Account to be reduced by the amount requested on a recurring basis as provided above.

Employee's Signature (required) ____________________________________ **Date** ____________________________

Return completed form to: The Taben Group, c/o Surency Life & Health, PO Box 789773, Wichita, KS 67278.

Surency © 2018