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MEDCOST℠ BENEFIT SERVICES

Dependent Care Recurring Charge Form

Flexible Spending Accounts For Dependant Care

Instructions: Use this form to submit one claim for recurring child care service that will occur multiple weeks at the same rate. Indicate the date range of the recurring child care below. The total amount of the claim will be divided equally between the number of reimbursements from the beginning service date to the ending service date indicated below. Please note, due to IRS regulations, you can not be reimbursed for eligible expenses until an amount equal or greater than the expense has been withheld from your payroll and deposited, into your Flexible Spending Account, and expenses have been incurred and paid to the dependent care provider by you, the plan participant.

Account Holder Information

Last Name	First Name	Group Number M014
Address (Check if new address) ☐		Member ID
Email Address		Contact Number

Dependent Care Reimbursement

Dependent care expenses are eligible for children through age 12 or for dependent, disabled adults. The IRS requires that the name, address, and tax id number of your dependent care provider be on file with the administrator.

Provider Name		Provider SS # / TIN	
Street Address	City	St	Zip
Provider Signature		Date	

Dependent Name - 1 ___ ___/___ ___/___ ___ to ___ ___/___ ___/___ ___
Service Date (MM/DD/YY) Service Date (MM/DD/YY)
_____
Number of weeks included in service dates: _____
Weekly Expense: _____
Total reimbursement for service dates: _____

Dependent Name - 2 ___ ___/___ ___/___ ___ to ___ ___/___ ___/___ ___
Service Date (MM/DD/YY) Service Date (MM/DD/YY)
_____
Number of weeks included in service dates: _____
Weekly Expense: _____
Total reimbursement for service dates: _____

Dependent Name - 3 ___ ___/___ ___/___ ___ to ___ ___/___ ___/___ ___
Service Date (MM/DD/YY) Service Date (MM/DD/YY)
_____
Number of weeks included in service dates: _____
Weekly Expense: _____
Total reimbursement for service dates: _____

Total Dependent Care Expenses Being Claimed for all Dependents **$**

Important! To prevent delays, please attach paid receipts or copies of bills (not canceled checks) to verify expenses.

Certification

I attest that these expenses have or will be incurred while I have been a covered participant, and to the best of my knowledge are reimbursable by the plan. I have not and will not be reimbursed for these amounts from any other source. If submitting a recurring reimbursement form with future dates, I agree and understand that it is my responsibility to notify MedCost Benefit Services if there is a change in providers, service dates, or the amount charged and paid to the dependent care provider.
PLEASE NOTE: Upon receipt of the first recurring expense reimbursement form, all available funds from previous deposits not used will be distributed on the first reimbursement cycle.

Signature	**Date**