This form should be completed each plan year, and as changes occur, when the participant wants to receive recurring reimbursement of dependent care expenses. In order to qualify for recurring reimbursements, your cost of dependent care per month must meet or exceed your monthly payroll deductions. If that is the case, reimbursements will be made to you as your payroll deductions post to your Dependent Care Account. Documentation must be retained for your records and provided to Flex Made Easy. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

Your Name (Last, First, MI)	Social Security No. or EID	Your Employer Name	
Address	**City**	**State**	**Zip Code**

Recurring Dependent Care Account Information - Please select only one

		Effective Date (mm/dd/yyyy)
	Start Recurring DCA: Please start my recurring reimbursement with the information provided in the Dependent Care Claims section	
	Change Recurring DCA Information: Please update my recurring reimbursement with the provided information as of the provided Effective Date	
	Stop Recurring DCA: Please stop my recurring reimbursement with the provided information as of the provided Effective Date	

If your cost of dependent care per month is less than your monthly payroll deductions or you have currently contributed more to your plan than you have incurred in expenses, you do not qualify for recurring dependent care and you will need to file claims as services are incurred.

Dependent Care Flexible Spending Account Claims

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided, and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

Name of Dependent	*Start Date of Service (Must be within current plan year)	*End Date of Service (Must be within current plan year or use December 31 for end of the year)	Total Amount Requested Over Service Period (NOT just the monthly amount)	Dependent Care Provider's Name and Tax ID	Provider's Signature
			$		
			$		
			$		

To the best of my knowledge the provided information is complete and accurate. By submitting this, I acknowledge my child is under the age of 13, the services are eligible dependent care expenses as defined by the IRS, that I have not been previously reimbursed for these expenses, and that I will not seek reimbursement from any other source. I understand that Flex Made Easy, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Flex Made Easy. I understand that Flex Made Easy may require me to submit any additional documentation, receipts and an updated request form at any time. I should retain a copy of all submitted documentation in the event of an IRS audit.

✓ **Employee Signature** _____ **Date** _____

Fax to: 1.866.686.FLEX (3539)
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NO COVER PAGE REQUIRED

Mail to: Flex Made Easy
410 Archibald St, #100
Kansas City, MO 64111

Email to: info@FlexMadeEasy.com