region 1 | BENEFITS TODAY
Employee Benefit Administration Services

Automatic Dependent Care Reimbursement Request Form

Complete all of the following information on this page for automatic reimbursement of eligible dependent care expenses. Any missing information may result in a delay in processing your request. You must complete a new form each year. Please read the Participant Certification thoroughly at the bottom of the page. You may only be paid for expenses up to the amount that is available in your Dependent Care Account, so if the cost of daycare expenses exceeds your payroll deduction amount, reimbursement will be made as payroll deductions post to your Dependent Care Account.

Completed forms can be e-mailed to support@r1benefitstoday.org or faxed to 218-236-2368

Participant Information (* = Required Fields)

* Plan Year	* Employer Name		* Group #
* Participant Name	* Participant ID Number		
Participant Address	City	State	Zip Code
* Participant Daytime Telephone Number	Participant E-mail Address		

Dependent Care Information (* = Required Fields)

/ /	* Effective Date (*mm/dd/yyyy*)	Annual Dependant Care Election	$

*** Please Check only one box**

	Start Auto Dep. Care – Start the automatic reimbursement of my dependent care expense, effective as of the date specified above.
	Change Auto Dep. Care Information – Update my automatic reimbursement information, effective as of the date specified above.
	Stop Auto Dep. Care – Stop the automatic reimbursement of my dependent care expense, effective as of the date specified above.

* Name of Dependent	* Date of Birth (*mm/dd/yyyy*)	* Daycare Start Date (Must be within current plan year)	* Daycare End Date (Must be within current plan year)
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /

Dependent Care Provider Certification (to be completed by daycare provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

$_____Per month / week
*** Cost per month or week (circle one)**

_____
*** Provider's Name (please print)**

_____
*** Provider's Signature**

Participant Certification:

I certify that the information provided above is complete and accurate to the best of my knowledge. I certify that the request I am submitting is an eligible expense as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Region I, 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. I understand that it is my sole responsibility to inform Region I of any changes in the daycare service provided or costs listed above. I accept full liability for timely notification of any changes, and I am responsible for maintaining all other necessary documentation that may be required by the IRS for proof of services provided.

Participant Signature: _____ Date: _____

OFFICE USE :	