Dependent Care Recurring Expense Form

PacificSource ADMINISTRATORS

PO Box 2797 ◆ Portland, OR 97208-2797
Phone (541) 485-7488 ◆ (800) 422-7038
FAX (866) 446-6090
Submit claims electronically through MyFlex at: PacificSource.com/PSA

EMPLOYEE INFORMATION

Employer name _____ 11-digit member ID _____

Employee last name _____ First name _____ Middle initial _____

Home phone _____ Work phone _____ Email address _____

DEPENDENT INFORMATION

Dependent name _____ Date of birth _____

Dependent name _____ Date of birth _____

Dependent name _____ Date of birth _____

DAYCARE PROVIDER INFORMATION *(to be completed by daycare provider)*

Daycare provider name _____ Provider Tax ID _____

Provider rate _____ Frequency: ○ Weekly ○ Biweekly ○ Monthly Rate start date _____ Rate end date _____

Provider signature _____ Date _____

Examples of **Eligible** Dependent Care Expenses	Examples of ***Ineligible*** Dependent Care Expenses
• Daycare centers • Nanny services • Day camps • Preschool • Before and after school care • Elder care	• Meals • Overnight camps • Medical care • Educational expenses / tuition • Kindergarten • Misc. fees (*activity fees, field trips etc.*)

RECURRING CLAIM AUTHORIZATION

This form eliminates the need for additional documentation for recurring Dependent Care Expenses (DCE). **It is valid for the duration listed above, or the current plan year, whichever is less**. Please note: Hourly rates cannot be set up as recurring expenses.

Please accept this form and register me for recurring reimbursement of day care expenses through my DCE account. As payroll deductions are received, PSA will automatically generate reimbursement for expenses incurred. I understand I will need to complete a new DCE Recurring Expense Form **each plan year** or when my contract ends on the date shown above.

To the best of my knowledge, the statements in this Dependent Care Recurring Expense Form are complete and true. I am claiming reimbursement only for eligible expenses incurred for eligible plan participants during the applicable Plan Year. I certify that these expenses have not been, nor are they expected to be, reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my DCE flexible spending account to be reduced by the amount requested above.

Employee Signature (required) _____ **Date** _____