Discovery Benefits
FSA • HSA • HRA • TSA • COBRA • Billing Solutions

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Recurring Dependent Care Request Form

Completion Guide

Step 1: Participant Information

- Complete the required fields (*).
- Changes to your profile can be made by logging in to your account at www.discoverybenefits.com.
- Please write legibly. Missing information may delay the processing of your claim.

Step 2: Recurring Dependent Care Account (DCA) Information

- Select one option:
  Start Recurring DCA: Select this box if you are starting a new recurring reimbursement for dependent care expenses.
  Change Recurring DCA Information: Select this box if need to change information on a current recurring reimbursement.
  Stop Recurring DCA: Select this box to stop receiving recurring reimbursement.

Step 3: Dependent Care Provider Information and Signature

This section needs to be completed by your dependent care provider

- Dependent Name: Name of the dependent(s) receiving care, each dependent listed separately
- Start Date: First day of the plan year that your dependent(s) received care
- End Date: Last day to the plan year that your dependent(s) will receive care
- Provider's Signature: Signature of dependent care provider
- Cost per week: Total dependent care expenses per week

Step 4: Participant Certification

Read the certification and submit the completed Recurring Dependent Care Form to Discovery Benefits.

- Send your claim to:
  Mail: PO Box 2926; Fargo, ND 58108-2926
  Fax: 1-866-451-3245

Documentation Requirements

Documentation must be retained for your records and provided to Discovery Benefits when requested to do so.

Documentation for dependent care expenses, required by the IRS, includes a third party receipt containing the following information (please be advised if a receipt is unavailable a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/eligible expenses where services have not yet occurred

Direct Deposit

Signing up for free direct deposit through www.discoverybenefits.com your online account will allow funds to be sent electronically to a checking or savings account. **Note**: No reimbursement limit applies to direct deposit.

By completing the online steps for establishing direct deposit, you are certifying the information provided is accurate. Further, the completion and submission of this information authorizes Discovery Benefits to issue payment directly to the specified account unless notified to do otherwise. You understand and agree that Discovery Benefits reserves the right to reverse any ACH deposit where an error occurs, in accordance with banking regulations.

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Recurring Dependent Care Request Form

This form is to 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 Discovery Benefits when requested to do so. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

*= Required Fields

Step 1: Participant Information

*Participant Name (First, MI, Last)

*Social Security Number

*Employer Name

*Employee ID

Updates or changes to your information can be made by logging into your account at www.discoverybenefits.com

Step 2: Recurring Dependent Care Account (DCA) Information

*Please select only one.

	Start Recurring DCA: Please start my recurring reimbursement with the information provided in Step 3.	**Effective Date** *(mm/dd/yyyy)*
	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.	

Step 3: Dependent Care Provider Information and Signature (to be completed by the provider)

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.

*Dependent(s) Name	*Start Date of Service *Must be within current plan year (mm/dd/yyyy)*	*End Date of Service *Must be within current plan year (mm/dd/yyyy)*	*Provider's Signature	*Cost Per Week

If your cost of dependent care is less than your payroll deductions or you have currently contributed more to your plan than you have incurred in expenses, you will be reimbursed on a weekly basis and should consider direct deposit for reimbursements if you are not signed up.

Signing up for free direct deposit through your online account at www.discoverybenefits.com will allow funds to be sent electronically to a checking or savings account. **Note**: No reimbursement limit applies to direct deposit.

Step 4: Participant Certification

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 Discovery Benefits, 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 Discovery Benefits. I understand that Discovery Benefits 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.

By submitting this form I certify the above.