Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when the accountholder wants to receive recurring reimbursement of dependent care expenses. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to HSA Bank when requested to do so.

Please complete and return this form to HSA Bank by email to hsaforms@hsabank.com, fax to 877-851-7041, or mail to P.O. Box 939, Sheboygan, WI 53082-0939.

For assistance, our U.S.-based Client Assistance Center has English and multilingual representatives available 24 hours a day, 7 days a week, at 1-800-357-6246.

All fields are required.

Step 1: Accountholder Information		
Employer Name: (Do not abbreviate)	Employer ID:	
Accountholder First Name:	Accountholder Middle Initial:	Accountholder Last Name:
Day Telephone:	Full 9-digit Social Security Number:	
Updates or changes to your information can also be made by logging into your account at myaccounts.hsabank.com.		

Step 2: Auto-Dependent Care (DCA) Information		
Please select only one to start, change, or stop reimbursement.		**Effective Date (mm/dd/yyyy)**
☐	**Start Recurring DCA:** Please begin recurring reimbursement of my dependent care expenses.	**A.**
☐	**Change Recurring DCA Information:** Please update my recurring reimbursement information.	**B.**
☐	**Stop Recurring DCA:** Please stop recurring reimbursement of my dependent care expenses effective by the date specified in Box C.	**C.**

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

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 eliminate the necessity for the accountholder to provide receipts for reimbursement purposes.		
Providers Name:	Reimbursement requested per ☐ Month ☐ Week $	Provider's Signature:
Providers Name:	Reimbursement requested per ☐ Month ☐ Week $	Provider's Signature:

Step 4: Accountholder Certification	
To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses 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 HSA Bank, 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 HSA Bank. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. By submitting this form, I certify the above.	
Accountholder Signature:	Date: