Recurring Dependent Care Request Form

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This form is to be completed each plan year and as changes occur when the member 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. Receipts can be uploaded through the member website or faxed to 1-855-764-5689. 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: Accountholder Information

*Employer Name (Do not abbreviate)	* Employee ID
*Member Name (First, MI, Last)	*Social Security Number
*Day Telephone	

Updates or changes to your information can also be made by logging into your account at http://MyAccounts.hsabank.com

Step 2: Auto-Dependent Care (DCA) Information

*Please select only **one** to start, change, or stop reimbursement.*

	Start Recurring DCA: Please begin recurring reimbursement of my dependent care expenses.	**Effective Date (mm/dd/yyyy)**
	Change Recurring DCA Information: Please update my recurring reimbursement information	**A.**
	Stop Recurring DCA: Please stop recurring reimbursement of my dependent care expenses effective by the date specified in Box B.	**B.**

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

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.

*Provider's Name	$ per month/week	*Provider's Signature

*Cost per month/week (circle one)

*Provider's Name	$ per month/week	*Provider's Signature

*Cost per month/week (circle one)

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.

*Member Signature	*Date

Mail this signed form to:
HSA Bank
P.O. Box 2744
Fargo, ND 58108-2744

You may also fax: 1-855-764-5689

Questions? Please call the Client Assistance Center at **1-855- 731-5213.**