CONTINUON SERVICES

RECURRING DEPENDENT CARE CONTRACT & CLAIM FORM

Personal Information: (Please print)			
Employer Name:		**Request Date:**	
Employee Name:		**Email Address:**	
Employee SSN:		**Daytime Phone Number:**	

Dependent Care Reimbursement Request Expenses (Supporting documentation is required for all claims)

Dependent's Name	Relationship to Employee	Age	Service Start Date	Service End Date	Requested Reimbursement
				Total:	

Dependent Care Provider Affidavit Information			
Provider's Name:		**Provider's Tax ID or SSN:**	
Cost of Service:		**Provider Rate Start Date:**	
☐ **Weekly** ☐ **Bi-weekly** ☐ **Monthly** Hourly claims cannot be recurring.		**Provider Rate End Date:**	
Dependent Care Provider: Please read the following statement then sign and date: *I VERIFY THAT THE ABOVE DESCRIBED CHARGES ARE ACCURATE.*			
Provider's Signature:	**X**	**Date:**	

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT REQUEST

I HEREBY CERTIFY THAT: the above information is correct; I have not received, nor will I seek reimbursement for the expenses listed above from any other plan, including through the use of my Continuon Services MasterCard; the above listed expenses are not eligible for reimbursement under any other plan. ***I ALSO UNDERSTAND THAT:*** reimbursement is not a guarantee that this payment is tax free; healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return; dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; reimbursements will be made only up to the cash balance in my Dependent Care Account; unpaid claims are reimbursed as more money is credited to my account. Unused funds at the end of the plan year will be forfeited. ***I VERIFY THAT I MAKE REGULAR PAYMENTS TO THE DEPENDENT CARE PROVIDER DESCRIBED ABOVE FOR THE DEPENDENTS NAMED ABOVE. I AUTHORIZE CONTINUON SERVICES, LLC TO AUTOMATICALLY REIMBURSE ME THE AMOUNT STATED ABOVE FROM MY DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. I AGREE THAT IF THE AMOUNT CHANGES OR IF, FOR ANY REASON, SUCH AS ILLNESS OR VACATION, THE EXPENSES ARE NOT INCURRED AS SCHEDULED, I WILL NOTIFY CONTINUON SERVICES, LLC IMMEDIATELY IN WRITING. THIS FORM IS VALID FOR ONLY THE CURRENT PLAN YEAR OR UNTIL THE CONTRACTED RATE DESCRIBED ABOVE CHANGES, WHICHEVER TERM IS LESS*. I UNDERSTAND THIS FORM IS NOT VALID UNLESS SIGNED BY MY DEPENDENT CARE PROVIDER. I UNDERSTAND THE RIGHT TO SUBMIT CLAIMS VIA THIS PROGRAM MAY BE DISCONTINUED AT ANY TIME. I UNDERSTAND THAT THE RULES AND REGULATIONS THAT GOVERN FLEXIBLE SPENDING ACCOUNTS ARE A MATTER OF LAW AND ARE STRICTLY ENFORCED BY THE INTERNAL REVENUE SERVICE (IRS). I UNDERSTAND THAT HOURLY SERVICES CANNOT BE SET-UP AS RECURRING.***

Employee Signature:	**X**	**Date:**	

If you have any questions, please contact us at: 1-877-747-4141 or fsa@csllc.com

Submit to: Continuon Services, LLC
Attn: FSA Administration
P.O. Box 7127
Atlanta, GA 30357-7127

or

Fax to: 1-866-593-7125

**** IF THE CONTRACTED RATE WITH YOUR PROVIDER CHANGES, A NEW FORM MUST BE SUBMITTED. A NEW FORM MUST BE SUBMITTED EACH PLAN YEAR EVEN IF THE CONTRACTED RATE DOES NOT CHANGE.***