BSI BENEFIT SOLUTIONS, INC.
Employee Benefit Administration

Automatic Dependent Care Request Form

Dear Dependent Care Provider:

This participant has requested regularly scheduled payments each month for reimbursement of dependent care services based on their employer's payroll cycle. The IRS requires that proof of services (a receipt) be provided by the care provider. Instead of submitting a receipt each month for reimbursement, this form will allow reimbursements to be sent to the participant automatically.

Care Provider must agree to the following:
I have read the above and understand and verify that the participant listed below receives dependent care services, for which he/she regularly pays no less than $_____ per week.

Care Provider

Provider Name_____ **Tax Id Number**_____

Dates of Service ____/____/_____ **through** ____/____/_____

_____ ____/____/_____
Care Provider's Signature **Date**

Participant Claim Information

Dependent Child's Name _____ **Date of Birth** ____/____/_____

Important! A copy of the latest receipt for childcare services must be included before this form can be processed

I understand that amounts may not be reimbursed until (1) payroll deposits have funded my dependent care account AND (2) dependent care expenses have actually occurred. If dependent care services cease or decrease from the amount stated on this form, I understand that it is my sole responsibility to inform Benefit Solutions, Inc. in a timely manner of the change.

_____ ____/____/_____
Participant's Signature **Date**

Please return form to Benefit Solutions, Inc. Attn: Flex Spending Department
Email: flexspending@bsitpa.com
Fax: 866-727-2106
Address: PO Box 6, 12121 Harbour Reach Dr, Ste 105, Mukilteo, WA 98275

*For more information or question about your Consumer Directed Healthcare Plan(s), please contact BSI at **206-859-2694** or email flexspending@bsitpa.com.*