



## 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 Vimly Benefit Solutions, Inc. in a timely manner of the change.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Participant's Signature Date

Please return form to Vimly Benefit Solutions Attn: Flex Spending Department  
Email: [flexspending@vimly.com](mailto:flexspending@vimly.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 Vimly at 206-859-2694 or email [flexspending@vimly.com](mailto:flexspending@vimly.com).*