

Automatic Dependent Care Request Form

This form is to be completed each plan year that the participant wants to receive automatic reimbursement of dependent care expenses. Should the cost of daycare per month meet or exceed the monthly payroll deduction, reimbursements will be made as payroll deductions posted to your Dependent Care Account. If the monthly cost of daycare is less than the monthly payroll deductions, reimbursement will be made once per month at the end of the month.

Step 1: Participant Information

*=Required Fields

<input type="text"/>	<input type="text"/>
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*Employer Name (Do not abbreviate)

*Employee ID

<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
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*Participant Name (First, MI, Last)

*Social Security Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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*Day Telephone

Updates or changes to your information can also be made by logging into your account at www.mycdh.usbank.com

Step 2: Auto-Dependent Care (DCA) Information

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

Start Auto-DCA: Please begin automatic reimbursement of my dependent care expenses	Effective Date (mm/dd/yyyy)
Change Auto-DCA Information: Please update my automatic reimbursement information with the information provided, effective as of the date specified in Box A.	A.
Stop Auto-DCA: Please stop automatic reimbursement of my dependent care expenses effective as of the date specified in Box B.	B.

*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 participant to provide receipts for reimbursement purposes.

<input type="text"/>	\$ <input type="text"/> per month/week	<input type="text"/>
*Provider's Name	*Cost per month/week (circle one)	*Provider's Signature
<input type="text"/>	\$ <input type="text"/> per month/week	<input type="text"/>
*Provider's Name	*Cost per month/week (circle one)	*Provider's Signature

Step 4: Participant 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 U.S. 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 U.S. 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.

<input type="text"/>	<input type="text"/>
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*Participant Signature

*Date

Mail this signed form to:
 U.S. Bank Healthcare Payment Solutions
 c/o HCB CS
 P.O. Box 6122
 Fargo, ND 58108-6122

You may also fax: (888) 403-5029

Questions? Please call **U.S. Bank Consumer Services** at (877) 470-1771 (M-F, 7 a.m.-7 p.m. CT).

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