2018 Automatic Reimbursement Request Form
Salt Lake County Dependent Care Flexible Spending Account

Employee's Last Name **First Name**

Street Address

City **State** **Zip Code**

SSN or EID or PIN

Use this form to start, change, or stop automatic reimbursement. Check the appropriate box below and enter the effective date and details of the care below. ***This form is only valid for the 2018 plan year. A new form will need to be completed each plan year.***

☐ Start automatic reimbursement ☐ Change amount of automatic reimbursement ☐ Stop automatic reimbursement

Enter Effective Date of Requested Start/Change/Stop: _____

Only qualifying dependent care services may be paid. If your care provider certifies the care to be provided below, you may request to be reimbursed automatically each month or each pay period. To substantiate your claim, **simply have your provider sign below to certify that the care will be provided.** If your provider signs below, no other supporting documentation is required. *If you have more than one provider, you will need to complete a separate form for each provider.*

Name of Dependent	Age	Dates Care Will Be Provided MM/DD/YY thru MM/DD/YY	Type of Dependent Care Service	Monthly Cost of Care
			○ Child Care ○ Preschool ○ Before/After School ○ Summer Day Camp ○ Adult Day Care	$
			○ Child Care ○ Preschool ○ Before/After School ○ Summer Day Camp ○ Adult Day Care	$
			○ Child Care ○ Preschool ○ Before/After School ○ Summer Day Camp ○ Adult Day Care	$
			Monthly Total	**$**

*** Day Care Provider or Care Facility Certification**

I hereby certify that I will provide dependent care services during the time period(s) detailed above. I also certify that these expenses are not for overnight camp, lessons or classes to learn a specific skill or sport, or for educational sessions or classes.

Name of Provider: _____

Address of Provider: _____ Telephone # of Provider: ( ) _____

Original Signature: _____ Date: _____

Participant Certification

I certify that all expenses for which reimbursement is claimed by submission of this form will be incurred for a qualifying dependent during a period while I will be covered under my employer Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. **If the cost of services change or if my dependent care provider changes, I will submit a new form.** I certify any claimed Dependent Care expenses are work-related to allow me and, if married, my spouse to work, are primarily for the protection and well-being of my dependent and were provided for my dependent under the age of 13 or for my dependent who is incapable of self-care. **I certify that any claimed Dependent Care expenses are not for overnight camp, lessons or classes to learn a specific skill or sport, or for educational sessions or classes.** I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. **I understand that it is my responsibility to notify ASIFlex if the dependent care provider stops providing day care services.**

✓ Employee Signature_____ Date_____

FAX TO: 1-877-879-9038
PAGE_____OF _____
NO COVER PAGE REQUIRED

MAIL TO: ASI
PO BOX 6044
COLUMBIA, MO 65205

You will need the provider's tax ID number when you file your taxes.
A claim will only be processed with a completed signed claim form.
Claims are not accepted by email due to privacy/security concerns.