



# Dependent Care Contract

Submit this completed form with your reimbursement request either online or via fax or mail.	<b>Fax</b>	<b>Mail</b>
	608.663.2762	TASC, P.O. Box 7308 Madison, WI 53704-7308

A new contract is required at the beginning of each new plan year. Use this form to verify dependent care expenses and submit a copy with each reimbursement request.

## PARTICIPANT INFORMATION

Employer Name:		Employer ID:	
Individual First Name:		Last Name:	
TASC ID:		Email Address:	
Primary Phone:		Mobile Phone:	
Primary Address:	Address 1:		Apt:
	Address 2:		
	City:		
	State:		ZIP:      +4:

*All fields required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.*

## DEPENDENT INFORMATION

**List your spouse/dependent children below:**

Last Name	First Name	Age



**PROVIDER CERTIFICATION**

Provider Name:				Tax ID:			
Provider Address:	Address:					Suite:	
	City:						
	State:		ZIP:		+4:		

I certify the total cost of qualified child care/adult services below have been provided during the period indicated and will continue for future periods through the Service Period End Date below for the dependents on this form unless the contract for services is terminated.

Total Amount:						
Duration (select one):	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other:					
Service Period:	Start Date:			End Date:		

\_\_\_\_\_  
Signature of Service Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**PARTICIPANT CERTIFICATION**

I understand that reimbursements (a) are limited to my Dependent Care Spending Account (DCSA) annual contributions, (b) may not exceed my DCSA year-to-date available balance at the time of the reimbursement request, and (c) are for services already incurred.

I understand and agree that I must inform TASC in writing (a) if the amount charged for the dependent care services changes, (b) if the service is terminated, and/or (c) of any reason the expenses are not incurred. If I fail to notify TASC I jeopardize the tax-free nature of my reimbursements and will be required to repay the plan with after-tax dollars.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date