



EMPLOYER NAME _____

DEPENDENT CARE REIMBURSEMENT CONTRACT

Social Security No.: _____

Employee's Name: _____
Last First Middle

The purpose of this contract is to submit a single form for reimbursement of the Dependent Care Account. By completing this form, I am stating that my day care provider requires that I pay at the beginning of the month for services provided. If my provider changes during the plan year, a new contract must be submitted. The total annual amount of reimbursement are equal to my annual election. This is a pay to deposit type account and reimbursement will be paid from this account as payroll deposits are posted.

The undersigned participant in the Plan requests automatic reimbursement following the conditions below:

I(the provider) will receive \$ _____/month. Due on the _____ day of the month from:

_____ for the care of _____

(Employee) (Dependents)

during the period from _____ to _____ even if the child/children are absent.
(mm/dd/yyyy) (mm/dd/yyyy)

Child Care Provider Signature Date

Child Care Provider's Taxpayer ID# (Social Security Number or EIN)

Employee's Signature Date

Recommended: FlexConnect recommends that you sign up for direct deposit. You may select checking or savings. You will see your payment into your account 1 to 2 business days from the payment date viewed on the website. You can avoid the \$10 void and reissue fee if your check is lost in the mail. There is a 15 business day wait before a void and reissue begins.

I authorize FlexConnect to initiate electronic credit entries, and if necessary, debit entries and adjustments for any credit entries in error to my account.

Checking Account or Savings Account

ABA Transit Routing Number Account Number

Name, Address and Phone Number of Financial Institution

Phone Number

Submit to: FlexConnect, 55 W 14th St, Suite 101, Helena, MT 59601
Contact us at: Phone: (406) 442-3539 or (866) 640-3539 - Fax: (406) 495-3669
Email: flex@icmont.com
Visit our Website at www.insurancecoordinators.com