



## FlexSystem Dependent Daycare Contract

A new contract is required at the start of each new plan year. Use this form to substantiate Dependent Daycare expenses. Submit a copy with each Request for Reimbursement Form.

| 1 – PARTICIPANT INFORMATION  |  |
|------------------------------|--|
| Participant Name             |  |
| Participant 12-digit TASC ID |  |

| 2 – DEPENDENT INFORMATION |  |     |  |
|---------------------------|--|-----|--|
| Dependent Name            |  | Age |  |
| Dependent Name            |  | Age |  |
| Dependent Name            |  | Age |  |

| 3 – PROVIDER CERTIFICATION & INFORMATION  |   |         |          |       |
|---|---|---------|----------|-------|
| Provider Name   |   | Tax ID  |          |       |
| Provider Address  |   |         |          |       |
| I certify the total cost of qualified adult/child care services below have been provided during the period indicated for the dependents on this form. |   |         |          |       |
| TOTAL AMOUNT  | The total cost of qualified service is \$ |         |          |       |
| DURATION (circle one)   | Weekly                                    | Monthly | Annual   | Other |
| SERVICE PERIOD  | Start Date                                |         | End Date |       |
| <b>Provider Signature</b>   |   | Date    |          |       |

| 4 – PARTICIPANT CERTIFICATION   |  |      |  |
|---|--|------|--|
| I understand that reimbursements (a) are limited to my Dependent Care Account annual salary reduction plus any employer contributions (if applicable) to my Dependent Care Account, (b) may not exceed my Dependent Care Account 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. |  |      |  |
| <b>Participant Signature</b>  |  | Date |  |