RECURRING DEPENDENT CARE REQUEST FORM

1. Complete the information below. Be sure to provide all information requested by this Form. If the Form is incomplete, your claim will be denied.
2. Forward completed form to Participant Services:
   Email: ParticipantServices@AssociatedBank.com
   Fax: 920-327-6546
   Mail: Associated Bank, ATTN: MS 7004, PO Box 19097, Green Bay, WI 54307-9097

*Required Fields

Participant Information

*Employer Name (do not abbreviate)

*Participant Name (First, MI, Last)

*Birth Date (MM/DD/YYYY)

*Last 4 Digits of SSN Number

*Participant Mailing Address (cannot be a PO Box)

*City

*State

*Zip Code

Email Address

Day Telephone

Dependent Care Information

This form is to be completed each plan year. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care (DCA) Request Form. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to Associated Bank when requested to do so. Receipts can be uploaded through the Participant Portal or faxed to 920-327-6546.

Recurrence Status

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

☐ **Start recurring DCA:** Please begin recurring reimbursement of my dependent care expenses. I understand Associated Bank will request receipts as proof that expenses have been incurred.

☐ **Change Recurring DCA Information:** Please update my recurring reimbursement information with the provided information effective by:

(MM/DD/YYYY)

☐ **Stop Recurring DCA:** Please stop recurring reimbursement of my dependent care expenses effective by:

(MM/DD/YYYY)

Dependent's Information

*Dependent's Name	*Dependent's Social Security Number	*Dependent's 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)	*Service Type (choose one)
	___ - ___ - ____				☐ Child Care ☐ Adult Care[1]
	___ - ___ - ____				☐ Child Care ☐ Adult Care[1]
	___ - ___ - ____				☐ Child Care ☐ Adult Care[1]

[1]If choosing Adult Care as the Service Type, you must provide a letter from a doctor or a Medical Necessity Form that identifies that the dependent is physically or mentally disabled and unable to self-care.

Dependent Care Provider Information (to be completed by the provider)

If there is more than one provider for the dependent(s) identified above, please complete separate forms.

By signing below, I certify that either I or my organization provides care for the dependent(s) identified above. I further 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.

Please check one: ☐ Cost per month ☐ Cost per week $ _____

*Provider's Name

*Provider's Signature *Date

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 set forth by IRS Code and the plan documents) for my dependent(s). I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that Associated Bank, including its affiliates, 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 on my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Associated Bank. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

*Participant Signature *Date