

**Dependent Childcare Annual Request Form 2024
For "Standing Request Reimbursement"**

Employee Information:

Employer _____

Employee _____ SSN _____
Last First Middle

Address: _____
Street City State Zip Code

Phone Number _____

Eligible Dependents: _____

Daycare Provider Information:

Name _____ Tax ID _____

Address _____
Street City State Zip Code

Phone Number _____

Standard Fee \$ _____ per Week Month
 Other* _____
*(may require additional information)

Service Effective Date: _____ thru _____

(Only service dates between **01/01/2024 and 03/15/2025** are eligible for reimbursement during the **2024** plan year. This form must be filled out every year in order to receive standing reimbursement.)

Daycare Provider's Signature _____ *Date* _____

I certify that the above information is correct. In the event that there are any changes and/or reductions in the above fees, I will notify Auxiant immediately to discontinue automatic reimbursement until such time that I deliver new documentation for my amended Annual Request.

Employee's Signature _____ *Date* _____

Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of themselves, then they are deemed to have monthly earnings of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes or is your child or stepchild and is under age 19.

Submit claims via secure message on www.auxiant.com, fax to 319-739-1109, or mail to Auxiant, Attn: Flex Department, PO Box 75008, Cedar Rapids, IA 52407-5008