# RECURRING DEPENDENT CARE REQUEST

Voya Benefits Company, LLC
*A member of the Voya® family of companies*
Customer Service: PO Box 929, Manchester, NH 03105
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASInfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). Custodial services provided by an approved HSA custodian as indicated in the applicable custodial agreement. For all other products, administration services provided in part by WEX Health, Inc.

This form is to be completed each plan year and as changes occur when the participant wants to receive recurring reimbursement of dependent care expenses. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to Voya Financial when requested to do so. Receipts can be uploaded through the participant portal or faxed to 855-370-0670. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request.

## STEP 1: CONSUMER INFORMATION

Consumer Name *(Required) (First)* ______________________ *(Last)* ______________________

Employer Name *(Required)* ______________________

Birth Date *(mm/dd/yyyy) (Required)* ______________ Social Security Number (SSN) *(Required) (Last 4 digits only.)* __________

Daytime Phone *(Required)* ______________ Email ______________________

Permanent Address *(Required)* ______________________

City ______________________ State ________ ZIP ______________

## STEP 2: AUTO-DEPENDENT CARE ACCOUNT (DCA) INFORMATION

2a. Recurrence Status *(Select only one to start, change, or stop reimbursement.) (Required)*

☐ **Start Recurring DCA:** Begin recurring reimbursement of my dependent care expenses. I understand Voya Financial will request receipts as proof that expenses have been incurred.

☐ **Change Recurring DCA Information:** Update my recurring reimbursement information with the provided information effective by the date specified in box A.

A. Effective Date *(mm/dd/yyyy)* ______________________

☐ **Stop Recurring DCA:** Stop recurring reimbursement of my dependent care expenses effective by the date specified in box B.

B. Effective Date *(mm/dd/yyyy)* ______________________

2b. Dependent Information *(Required)*

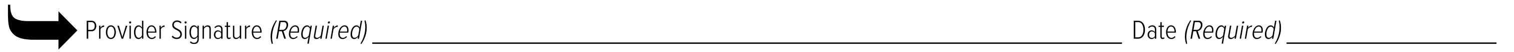
| Dependent Name *(First, Last)* *(Required)* | Dependent SSN *(Required)* | Dependent Birth Date *(mm/dd/yyyy)* *(Required)* | Start Date of Service *(Must be within current plan year)* *(Required)* | End date of Service *(Must be within current plan year)* *(Required)* | Service Type *(Select one.)* *(Required)* |
|---|---|---|---|---|---|
| | | | | | ☐ Child Care<br>☐ Adult Care [1] |
| | | | | | ☐ Child Care<br>☐ Adult Care [1] |

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

## STEP 3: DEPENDENT CARE PROVIDER INFORMATION AND SIGNATURE *(To be completed by the provider.)*

I 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.

Cost *(Required)* $____________________ Cost per *(Select one.) (Required)*: ☐ Month ☐ Week



Provider Signature *(Required)* ____________________ Date *(Required)* __________

Provider Name *(Please print.) (Required)* ____________________

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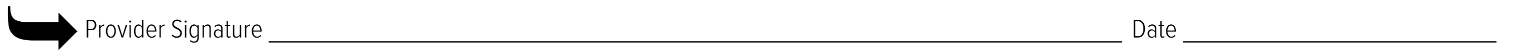
Cost $____________________ Cost per *(Select one.)* : ☐ Month ☐ Week



Provider Signature ____________________ Date __________

Provider Name *(Please print.)* ____________________

## STEP 4: 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 defined by the Internal Revenue Service (IRS) and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Voya Financial, including its agents and employees, will be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax Identification Number (TIN), and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Voya Financial. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form, I certify the above.

Participant Signature *(Required)* ____________________ Date *(Required)* __________

**Mail or fax the completed form to:**
**Voya Financial, PO Box 929, Manchester, NH 03105; Fax: 855-370-0670.**
**Questions? Call Customer Service at 833-232-4673 (Live customer support 24x7).**