CONSOCIATE HEALTH | GETMOR

Dependent Care Reimbursement & Contract Form

Employee name

Social Security or ID #

Company/Employer Name

Employee Mailing Address
(P.O. Box or Street Address)

Employee Phone

Employee Email

Date of Service	Claim Amount	Complete Description of Eligible Expense	Provider of Service / Merchant
TOTAL			

DEPENDENT CARE EXPENSES - Send copies of records supporting each Dependent Care expense item listed or have your Dependent Care Provider sign and date the statement below with their tax identification, signature, and date. Where I have not included the address and taxpayer identification number of each Dependent Care provider listed above, I have done so because: I submitted it earlier this year, or the provider is a non-profit, religious, charitable or educational organization [under Section 501(c)(3)], or I was unable to obtain this information after diligently trying to obtain it.

I provided the Dependent Care services as stated.

Employee Signature

Dependent Care Provider (print and sign name)

Date

Provider Tax ID # or Social Security #

Date

Your signature is required for reimbursement. Failure to sign or complete this form in its entirety will delay processing. Incomplete forms will be returned.

********** OR....the following DCA "Contract" can be completed **********

When to Use This Contract: If you incur consistent Dependent Care expenses and can predict the annual amount you will be charged for the year, complete this contract to establish a recurring reimbursement amount. You only need to complete this contract one time per plan year unless you have a qualified status change.

A. Dependent Information *(Please Print)*	
Dependent Name:	Relationship to Employee:
Dependent Name:	Relationship to Employee:
Dependent Name:	Relationship to Employee:
B. Dependent Care Provider to Complete This Section *(Please Print)*	
Provider Name:	Tax ID or Social Security Number:
Cost of Service per. . . : ◯ (Month) ◯ (Bi-Weekly) ◯ (Weekly)	Total $ to be Charged for the Year:
Service Effective Dates: _____ (mm/dd/yy) **through** _____ (mm/dd/yy)	*I certify that the rates shown here are accurate for the effective dates specified in the section.* Provider Signature _____

C. Employee to Read and Sign This Section

The Dependent Care expenses claimed above (if applicable) enable me to be gainfully employed, are attributable to the care of a qualifying individual and have not been paid to a dependent. I certify these expenses submitted under this claim and when combined with expenses reimbursed previously this year do not exceed my (or, the lower of my spouse's) earned income. I hereby agree to notify GetMOR in writing of any changes in the above-stated costs. I authorize the above amount to be reimbursed through my Dependent Care Account. I certify the above-named individual(s) is/are declared by me as (a) dependent(s) for purpose of filing my federal income tax. I understand it is my responsibility to refrain from submitting Dependent Care claims during any period of the year when I cannot claim the individual(s) as my dependent(s) for federal tax purposes. If circumstances arise during the year causing the actual expense to be different than the amount projected, I will notify GetMOR at (888) 900-4MOR within 30 days.

Employee Signature _____ Date _____