DEPENDENT CARE CONTRACT

A new contract is required at the beginning of each plan year. Submit a copy with each reimbursement request online or via fax or mail.	Fax	Mail
	608-245-3623	PO Box 7308 Madison, WI 53704-7308

PARTICIPANT INFORMATION

Participant Name		Employer Name	State of Connecticut
Participant TASC ID		Email Address	

DEPENDENT INFORMATION

First Name	Last Name	Age

PROVIDER CERTIFICATION

Provider Name			Tax ID			
Provider Address	Street					
	City		State		ZIP	
Service Period Start Date						
Service Period End Date						
Total Cost	**$**	Duration	☐ Weekly	☐ Monthly	☐ Annual	☐ Other

I certify the total cost of qualified childcare / adult services above have been provided during the period indicated and will continue for future periods through the Service Period End Date above for the dependent(s) on this form unless the contract for services is terminated.

_____

Provider's Printed Name

_____ _____

Provider's Signature Date

PARTICIPANT CERTIFICATION

I understand that reimbursements (a) are limited to my Dependent Care benefit account annual salary reduction plus any employer contributions (if applicable) to my Dependent Care benefit account, (b) may not exceed my Dependent Care benefit 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) for 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 benefit plan with after-tax dollars.

_____ _____

Participant's Signature Date