DEPENDENT CARE CONTRACT
State of Connecticut

Submit this completed form to TASC via one of the following methods:	Online Service Request	Fax	Mail
	Log onto your online account and attach completed form via Support Request cttasc.com (click *Contact Us*)	(608) 663-2759	TASC PO Box 7308 Madison WI 53707-7308

A new contract is required at the start of each new plan year. Use this form to substantiate dependent care expenses and submit a copy with each Request Form.

CLIENT/CONTACT INFORMATION

For Employer to complete where applicable:

Client/Company Name:	**State Of Connecticut**	TASC ID #:	**4721-0392-1958**
Employer Class:	**NA**	Employer Division:	**NA**

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		MI:		Last Name:		
TASC ID # (if known):		Email Address:				
Primary Phone #:		Mobile Phone #:				
Primary Address:	Address Line 1:				Apt:	
	Address Line 2:					
	City:					
	State:		ZIP/Postal Code:		+4	

All fields required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

DEPENDENT INFORMATION

List your spouse/dependent children below:

LAST NAME	FIRST NAME	AGE

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PROVIDER CERTIFICATION

Provider Name:				Tax ID:		
Provider Address:	Address:				Apt:	
	City:					
	State:		Zip/Postal Code:		+4	
I certify the total cost of qualified adult/child care services below have been provided during the period indicated and will continue for future periods through the Service Period End Date below for the dependents on this form unless the contract for services is terminated.						
Total Amount (total cost of qualified service): **$**						
Duration (select one):	☐ Weekly ☐ Monthly ☐ Annually ☐ Other: _____					
Service Period:	Start Date:			End Date:		

Provider Signature: _____ **Date:** _____

Provider Name: _____
(Please Print)

PARTICIPANT CERTIFICATION

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

Participant Signature: _____ **Date:** _____

Participant Name: _____
(Please Print)

For assistance, call TASC toll-free at 888-698-1429