OPTUMBank®

Recurring Dependent Care Reimbursement Request

Please complete this form to establish a Recurring Dependent Care Reimbursement Request. In addition, you must send in a new Recurring Dependent Care Reimbursement Request Form for each new plan year.

Questions? Visit us online at mycdh.optum.com or call the number on the back of your debit card if you have any questions while completing this form.

1017 MCDH FSADC

1 Participant Information

Participant Name: | Last 4 of SSN:

Employer/Plan Sponsor Name:

2 Information about your Recurring Reimbursement Request

Please provide the information below about your recurring reimbursement request:

1. Which months would you like to be reimbursed? _____ through _____
   (Month/Year – Example: Jan 2017) (Month/Year – Example: Dec 2017)
2. What is the amount you would like to be reimbursed each month? $ _____

Important Note: The amount you are reimbursed each month cannot exceed your monthly contract payment amount. The amount you request each month will be deducted from your FSA until one or more of the following happen:

- Your available funds are used up
- The calendar year ends
- You drop/add/change your existing coverage
- You notify Optum Bank in writing to stop the monthly recurring reimbursements

3 Required Documentation

Please obtain provider certification prior to submitting the request for recurring reimbursements from your Dependent Care plan. If we are unable to read the documents due to the quality of the copy, we may need to request additional information.

Dependent Care Expenses	Date of service MM/DD/YY	Expense Amount	Name of Service Provider	Dependent Receiving Service		Provider Certification (Required)		
				Age	Name	Amount	Signature	Tax ID #
EXPENSE ❶		$				$		
EXPENSE ❷		$				$		
EXPENSE ❸		$				$		

4 Participant Signature

By submitting this form, I certify that: All expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan(s). All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(s). None of the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. I am fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission.

X _____ _____

Participant Signature Date

Where to return your form?

By Mail: Optum Bank, P.O. Box 30516, Salt Lake City, UT 84130
By Email: optumclaims@prod.sourcehov.com
By Fax: 1-855-244-5016

FSAs are administered by OptumHealth Financial Services.