Automatic Dependent Care Request Form

Please Print Clearly

CATAPULT

PERSONAL INFORMATION

Company Name:	**Social Security:**
Employee Name:	**Phone:**
Address:	**City, State, Zip Code:**
Email:	☐ Please check if this is a new address

AUTO-DEPENDENT CARE (DCA) INFORMATION

This form is to be completed each plan year the participant wants to receive automatic reimbursement of dependent care expenses. ☐ Start Auto-DCA ☐ Change Auto-DCA Information ☐ Stop Auto DCA

Effective Date _____

Dependent(s) Name & Date of Birth	Start Date of Service (Must be within current plan year)	End Date of Service (Must be within current plan year)

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.

Provider's Name, Tax ID, and Signature	Total Amount Requested
	$
	$

PARTICIPANT CERTIFICATION

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Catapult, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to notify The Employers Association. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

_____ _____

Participant Signature (**Void if not signed**) Date Signed

Send your completed form to:

Catapult

Attn: FSA Services

Fax: 704.944.6076 | Email: claims@letscatapult.org

9140 Arrowpoint Blvd, Suite 140, Charlotte, NC 28273