

CUSTOM BENEFIT ADMINISTRATORS

DEPENDENT CARE CERTIFICATION STATEMENT

****You Must Complete this form if you are electing Dependent Care.****

Instructions: Complete the sections below, sign and date the form under Section IV. Return the completed form to your employer.

New Plan Year Election: Complete Sections I, II & III

Plan Year: _____

Eff. Date: _____

Section I – Participant Information

Social Security Number _____

Company Name _____

Participant Name (Last, First, MI) _____

Participant Home Address _____

City, State Zip _____

Section II – Dependent Information

Name and relationship of Dependent for who services are provided.

NAME (First & Last) _____

RELATIONSHIP _____

NAME (First & Last) _____

RELATIONSHIP _____

NAME (First & Last) _____

RELATIONSHIP _____

NAME (First & Last) _____

RELATIONSHIP _____

Section III – Provider Information

Name and Address of the individual/organization providing care services and their Tax ID Number or Social Security Number (SSN).

PROVIDER NAME & ADDRESS _____

TAX ID OR SSN _____

PROVIDER NAME & ADDRESS _____

TAX ID OR SSN _____

PROVIDER NAME & ADDRESS _____

TAX ID OR SSN _____

If the individual who is providing services is related to you, please indicate the nature of the relationship and their age, if a child.

RELATIONSHIP _____

AGE _____

Section IV – Participant Authorization

Please remember, to be eligible for Dependent Care Assistance Plans, both parents (if living together) must be employed or in school, or have a mental or physical reason to not be caring for the child(ren).

If care is for a child(ren) of a divorced or legally separated employee, only the parent with custody for the majority of the year can claim dependent care Assistance expenses under a new flex plan, even if the other parent is financially responsible for providing the care.

I understand that I must complete and submit a new certification statement in the event that I change providers of dependent care services or if any of The above information should substantially change.

Participant Signature _____

Date _____

Custom Benefit Administrators
P.O. Box 1385
La Crosse, WI 54602-1385

If you have any questions, please call:
1-800-944-2188