DEPENDENT CARE CONTRACT

Submit this completed form via one of the following methods:	Online Support Request	Fax	Mail
	Log onto your online account at https://cda.basiconline.com/ and attach the completed form via Support Request	(269) 327-0716	BASIC PO Box 6278 Monona, WI 53716

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.

EMPLOYER INFORMATION

Client/Employer Name:		**Client/Employer ID #:**	
Division: (If applicable)			

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		**MI:**		**Last Name:**	
Benefits ID: (12 digit)		**Email Address:**			
Primary Phone #:		**Mobile Phone #:**			
Primary Address:	**Address Line 1:**			**Ste:**	
	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

SIGNATURES REQUIRED ON PAGE 2

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PROVIDER INFORMATION

Provider Name:				**Tax ID:**		
Provider Address:	**Address Line 1:**				**Apt:**	
	Address Line 2:					
	City:					
	State:		**Zip/Postal Code:**		**+4**	
Total Amount (total cost of qualified service): $						
Duration (select one):	☐ Weekly ☐ Monthly ☐ Annually ☐ Other: _____					
Service Period:	**Start Date:**			**End Date:**		

I certify the total cost of qualified adult/child care services below have been provided during the period indicated for the dependents on this form.

Provider Signature: _____ **Date:** _____

PARTICIPANT INFORMATION

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 BASIC 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 BASIC 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 toll-free 800-372-3539
Have your form, employer name, and your 12 digit Benefits ID# ready.
Full resources available on our web page: www.basiconline.com/cda