Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when the consumer wants to receive recurring reimbursement of dependent care expenses. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to Allegiance Advantage when requested to do so. Receipts can be uploadedthrough the consumer portal or faxed to (833) 480-7005. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

Instructions:

1. Complete all sections of this form.
2. Securely email, mail or fax completed form to:
   Secure Email: Allegianceform@healthaccountservices.com
   Address: P.O. Box 2396 Fargo, ND 58108-2396
   Fax: (833) 480-7005
3. If you have any questions about completing this form, please contact Allegiance Advantage Consumer Services at (877) 424-3570. We have representatives available Monday-Friday, 7:00 am to 7:00 pm CST.

Step 1: Consumer Information

*Required Fields

*Consumer Name (First, MI, Last)

*Employer Name

*Birth Date (MM/DD/YYYY) / /

*Social Security Number - -

*Phone Number ( ) -

*Permanent Address

Email Address

*City

*State

*Zip Code

Updates or changes to your information can be made by logging into your account at www.askallegiance.com

Step 2: Auto-Dependent Care (DCA) Information

2a) Recurrence Status

Please select only **one to start, change, or stop reimbursement.*

☐	**Start Recurring DCA:** Please begin recurring reimbursement of my dependent care expenses. I understand Allegiance Advantage will request receipts as proof that expenses have been incurred.	**Effective Date (mm/dd/yyyy)**
☐	**Change Recurring DCA Information:** Please update my recurring reimbursement information with the provided information effective by the date specified in box A.	**A.**
☐	**Stop Recurring DCA:** Please stop recurring reimbursement of my dependent care expenses effective by the date specified in box B.	**B.**

2b) Dependent's Information

*Dependent(s) Name(s)	*Dependent's Social Security Number	*Dependent's Date of Birth (mm/dd/yyyy)	*Start Date of Service (Must be within current plan year)	*End Date of Service (Must be within current plan year)	*Service Type *(Choose One)*
					☐ Child Care ☐ Adult Care**
					☐ Child Care ☐ Adult Care**

**If choosing Adult Care as the Service Type, you must provide a letter from a doctor or a Medical Necessity Form that identifies that the dependent is physically or mentally disabled and unable to self-care.

Allegiance℠ by Cigna Healthcare

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Step 3: Dependent Care 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 consumer to provide receipts for reimbursement purposes.

*Provider's Name	$ per week *Cost per week	*Provider's Signature
*Provider's Name	$ per week *Cost per week	*Provider's Signature

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Step 4: Consumer Certification

To the best of my knowledge, the information provided 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 Allegiance Advantage, including its agents and employees, will be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN), and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Allegiance Advantage. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. I acknowledge that this form may be electronically signed via a digitized version of my written signature or with a digital certification using my full name. I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

By submitting this form, I certify the above.

*Consumer Signature	*Date