OPTUM Bank®

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 optumbank.com or call the number on the back of your debit card if you have any questions while completing this form.

1017 HA FSADC

1 Participant information

First name, last name:	Last 4 of SSN:	Employer/plan sponsor name:
Participant address:	City, state ZIP:	

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 provider certification

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 Agreement and 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.

✗ _____ _____

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.

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Recurring Dependent Care Reimbursement Request

You can be automatically reimbursed for dependent care expenses by filling out one form instead of filing multiple claims throughout your plan year.

Here's how it works:

- If your cost of dependent care per month **meets or exceeds your monthly payroll deduction**, reimbursement will be issued as payroll deductions post to your Dependent DayCare Flexible Spending Account.
- If the cost of dependent care is **less than your monthly payroll deductions**, you will be reimbursed once per month at the end of the month.

To set up automatic dependent care reimbursement, complete the **Recurring Dependent Care Reimbursement Request form** by following the steps below. A new form should be completed each plan year. Changes can be made at any time by submitting an updated form.

Step 1: Participant information

- Enter the **employee's** name and last four digits of the social security number (SSN).
- Employer/Plan Sponsor Name is Qualcomm.

Step 2: Information about your recurring reimbursement request

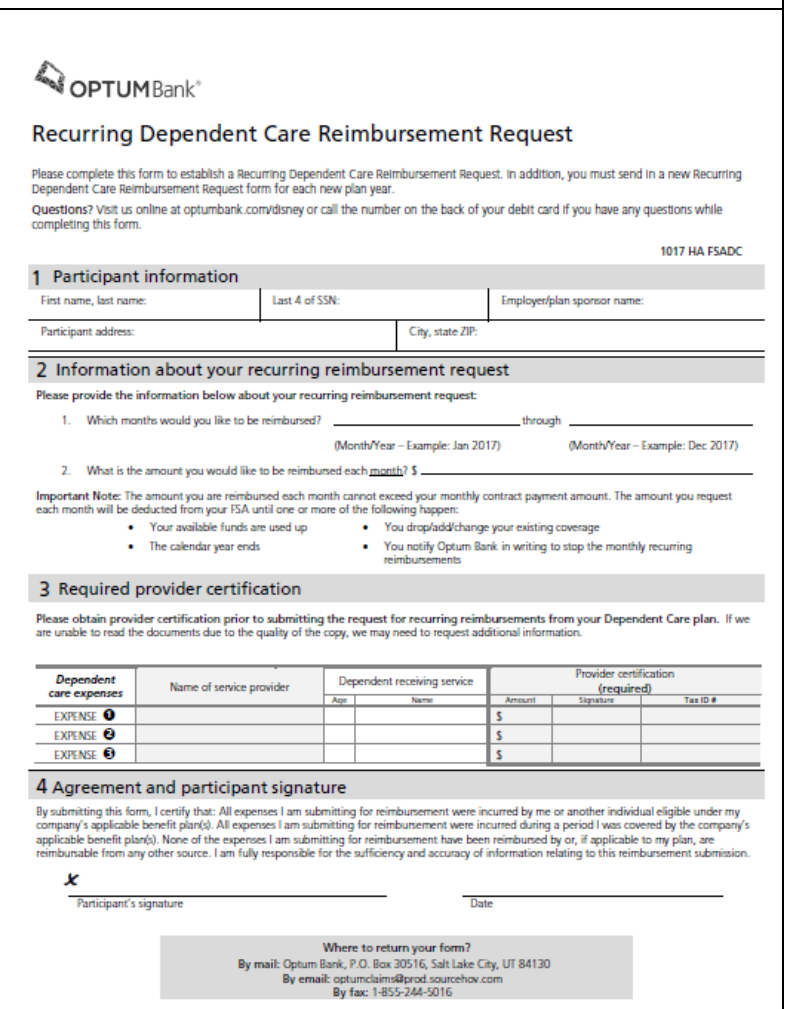
- List the months for which you would like to be reimbursed. The start date would typically be the month you are making the request through December of the calendar year.
- For the amount, divide the yearly contribution by the number of months for which you are requesting reimbursement. For example, if you are contributing $5,000 throughout the year and request reimbursement from January – December, the monthly amount would be $416.67 ($5,000/12 months).

Step 3: Required provider documentation

- Complete all details of this section, listing the name of the service provider, name and age of the dependent and estimated expense amount for dependent care services. Please obtain provider certification prior to submitting this request.
- Your dependent care provider must confirm the amount in the space provided, sign the document, and enter the provider's tax ID.

Step 4: Participant signature

- Sign and date the completed document, then mail, email or fax it to Optum Bank. Contact information is provided at the bottom of the form.



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X _____ _____
Participant's signature Date

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