BANK OF AMERICA

HEALTH & BENEFIT ACCOUNTS

Recurring dependent care request form

Instructions: This form is to be completed each plan year to set up recurring reimbursement for dependent care expenses. Reimbursements cannot be made until the expense has been incurred. You will receive a monthly "payment issued" confirmation email when the claim is processed and can also view the claim pending online.

Documentation must be retained for your records and provided to Bank of America when requested. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form. Please allow two business days for your form to be updated once received.

Please mail or fax the completed form and supporting documentation to:

Bank of America
c/o Health Account Services
PO Box 2203
Fargo, ND 58108

Fax: 844.590.0919

We're here to help you 24 hours a day, 7 days a week.

Customer Care Center:
800.718.6710

Online Chat:
myhealth.bankofamerica.com

All fields are required.

Step 1: Customer information

Employer name (If sponsored by an employer plan)

Customer name (First, middle initial, last)

Birth date (MM/DD/YYYY)

Social Security number

Day telephone number

Street address

Email address

City

State

Zip code

Continued on next page.

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 Bank of America will request receipts as proof that expenses have been incurred.

☐ Change recurring DCA information

Please update my recurring reimbursement information with the provided information effective by the date specified below.

Effective date (MM/DD/YYYY)

☐ Stop recurring DCA

Please stop recurring reimbursement of my dependent care expenses effective by the date specified below.

Effective date (MM/DD/YYYY)

2b: Dependent(s) information

Dependent name

Dependent Social Security number

Birth date (MM/DD/YYYY)

Start date of service (must be within current plan year)

End date of service (must be within current plan year)

☐ Child care ☐ Adult care

Service type (choose one)

Dependent name

Dependent Social Security number

Birth date (MM/DD/YYYY)

Start date of service (must be within current plan year)

End date of service (must be within current plan year)

☐ Child care ☐ Adult care

Service type (choose one)

Note: 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.

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 participant to provide receipts for reimbursement purposes.

Dependent's name

$ Cost per month/week (choose one)

☐ per month ☐ week

Provider's signature

Dependent's name

$ Cost per month/week (choose one)

☐ per month ☐ week

Provider's signature

Note: If you are unable to get your provider's signature on this form, you will need to provide the appropriate documentation (listed at the end of this form).

Continued on next page.

Step 4: Customer 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 Bank of America, including its agents and employees, will not 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 Bank of America. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Customer signature	Date (MM/DD/YYYY)

Acceptable forms of documentation

Provider signature in Step 3 of this claim form.

OR

Copy of itemized receipts of your dependent care expenses. Receipt must show:

- Name of the care provider.
- Tax ID# or Social Security number of the care provider.
- Date of services for which you are being charged.
- Amount you are being charged.
- Your dependent's name.

Non-approved documentation

- Credit/debit card receipt, canceled checks or other payment statements.
- Original copy of receipts or supporting documentation (retain originals and only send copies).