

# SISC FLEX Dependent Care Claim Form

**Employee Information (Please print clearly)**

<b>Employer:</b>			
<b>Name:</b>	First	MI	Last
<b>E-mail Address</b>		<b>SS#:</b>	
		<b>Phone:</b>	(    )

DEPENDENT CARE CLAIMS				
MM/DD/YR Date of Service From    To	Dependent Name	Age	Dependent Care Provider Name	Claim Amount
				\$
				\$
				\$
				\$
<b>Care Provider's Tax ID#</b>			<b>TOTAL</b>	\$ _____

PLEASE ATTACH A RECEIPT OR ITEMIZED BILLING **OR** HAVE PROVIDER CERTIFY BELOW.

**Provider's Certification:**

Name of Care Provider \_\_\_\_\_ Tax ID # \_\_\_\_\_

Care Provider's Relation to Employee, if any \_\_\_\_\_

Address where services were performed: \_\_\_\_\_

Number of individuals cared for at this center: \_\_\_\_\_ Date Services Provided (MM/DD/YR) \_\_\_\_\_

If registration or enrollment fee, please include the school year that applies: \_\_\_\_\_

I certify that the above described dependent care expenses were incurred by the employee named above.

Care Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail Claim Form and Supporting Documentation to:  
SISC Flex, P.O. Box 1808, Bakersfield CA 93303-1808 ♦ Or FAX to (661) 636-4063**

**Eligible reimbursements will be paid by check and mailed to your home address, or directly deposited to your bank account when authorized. Please notify SISC Flex of any change in address as soon as possible.  
Please retain a copy of the claim form and supporting documentation for your records.**

**Employee Certification for Reimbursement:** I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I agree to supply the taxpayer identification (Social Security) numbers of the care provider to the IRS on my tax return. Further, I understand that I have 90 days (run-out period) following the end of the plan year to file claims for the current year. Expenses for all claims must be incurred during the current plan year. If there is a question regarding eligibility of expenses or the dependency status, SISC Flex may require additional information. All claims and supporting documentation must be received by the SISC Flex office no later than March 31<sup>st</sup>.

**Employee's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*For SISC Flex Use Only*

Authorization \_\_\_\_\_ Date \_\_\_\_\_ Claim # \_\_\_\_\_

Amount Approved \_\_\_\_\_ Amount Pending \_\_\_\_\_ Amount Denied \_\_\_\_\_

Explanation: \_\_\_\_\_