# SISC FLEX
# Dependent Care Claim Form

**Employee Information (Please print clearly)**

| | | | |
|---|---|---|---|
| **Employer:** | | | |
| **Name:** | First MI Last | **SS#:** | |
| **E-mail Address** | | **Phone:** | ( ) |

| **DEPENDENT CARE CLAIMS** | | | | | |
|---|---|---|---|---|---|
| **MM/DD/YR Date of Service From** | **To** | **Dependent Name** | **Age** | **Dependent Care Provider Name** | **Claim Amount** |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| **Care Provider's Tax ID#** | | | | **TOTAL** | $ 0.00 |

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 31st.

**Employee's Signature** _____ **Date** _____

***For SISC Flex Use Only***

Authorization _____ Date _____ Claim # _____

Amount Approved _____ Amount Pending _____ Amount Denied_____

Explanation: _____

*Rev. Sept. 2012*