



# VitaFlex Dependent Care Claim Form

## Employee Data

<b>Company Name:</b>	
<b>Employee Name:</b>	
<b>Employee Social Security or ID Number:</b>	

## Dependent Information (complete once per year for each dependent)

Full Name	Date of Birth	Relationship to Employee

## Provider Receipt

Additional receipts are not necessary if the below section is completed by the dependent care provider. In lieu of the provider's signature, you may submit a receipt to substantiate this claim. For guidelines on sufficient documentation, please visit the 'Claims How-To' portion of our website at [www.vitaflex.net](http://www.vitaflex.net).

<b>Provider Name:</b>			
<b>Provider Tax ID Number:</b>			
Name of Dependent	Dates of Care		Charge for Care
	From:	To:	\$
	From:	To:	\$
	From:	To:	\$
	Total		\$

I certify that dependent care was provided to above referenced dependents on the dates indicated. The charges for care reflect dependent care for the dates indicated.

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Date

Provider Signature

## Verification

To the best of my knowledge and belief, the statements in this dependent care expense claim form are complete and true. I certify these claims are for valid dependent care expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the VitaFlex Dependent Care Reimbursement Plan. *These expenses have not been reimbursed under the VitaFlex plan previously nor have they been reimbursed under any other dependent care plan. Additionally, I do not expect any of these expenses to be reimbursable elsewhere in the future.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

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Date

Employee Signature

## New Phone/Address (Complete Only if Needed)

<b>New Preferred Phone Number:</b>	(       )
<b>New E-mail Address:</b>	
<b>New Home Address:</b>	

A photocopy of this form may be used if additional copies are needed.

For fastest service, fax claims to 650-964-FLEX (3539) or e-mail claims to [claims@vitamail.com](mailto:claims@vitamail.com).