



# VitaFlex Dependent Care Expense Claim Form

## Employee Data

<b>Company Name:</b>	<b>Vita</b>
<b>Employee Name:</b>	<b>Jane Smith</b>
<b>Employee Social Security or ID Number:</b>	<b>123-45-6789</b>

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

Full Name	Date of Birth	Relationship to Employee
<b>John Smith</b>	<b>02/13/04</b>	<b>Child</b>

## 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>Kid's House</b>		
<b>Provider Tax ID Number:</b>	<b>94-7654861</b>		
Name of Dependent	Dates of Care		Charge for Care
<b>John Smith</b>	From: <b>02/01/07</b>	To: <b>02/28/07</b>	<b>\$ 580</b>
	From:	To:	\$
	From:	To:	\$
	Total		<b>\$ 580</b>

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.

	<b>See Receipt</b>
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.

<b>03/01/07</b>	<b>Jane Smith</b>
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).**

# Kid's House

"Where kids can be kids"

## Tuition Receipt

Dear Jane Smith,

Per your authorization, we have drafted a check from your bank account below to cover the tuition for your child:

Check No	Check Date	Amount
159763	02/02/07	\$580

### Dependent Care Flexible Spending Account Submission Info

Provider Name: Kid's House, Mountain View

Address: 200 Central Avenue, Mountain View, CA 94043

Tax ID: 74-7654861

Description of Service: Child care for the month of February 2007

Child's Name: John Smith

If you have any questions, please feel free to call us at (650) 965- 1248.

Regards,  
Kid's House

This dependent care receipt is sufficient because it contains all the necessary information:

- 1) Provider's name
- 2) Dependent's name
- 3) Dates of service, rather than just the date paid
- 4) Description of service
- 5) Total cost for care
- 6) Tax ID (This is only necessary if we do not have the Tax ID number already on file)

You may also use our Consolidated Dependent Care Claim Form, which does not require documentation as long as it is completely filled out and signed by both the participant and provider.