Sharyland ISD

Flexible Spending Account Claim Form — Dependent Care Expenses

Employee Name _____ (Last, First) **SS#** _____

Employee Address _____ (Street Address, City, State, Zip)

How can we contact you? _____ (Daytime Phone) _____ (Personal E-mail address (optional))

For prompt claim service please make sure to:

1) complete this form;
2) attach receipt from provider, indicating service dates, name of dependent, expense amount, and provider name, address and social security number or EIN. Cancelled checks and credit card receipts alone are not sufficient.
3) sign the Claim Form below.

Dependent Name	Dates of Service	Provider Name and SS# or EIN	Amount requested
		Total Requested →	

Dependent care expenses are not payable unless adequate funds have been applied to your account.

Employee Certification:

I certify that the expense(s) listed above were incurred by me or my eligible dependent and qualify for reimbursement, that reimbursement is not available from any other benefit plan and that I have not received any reimbursement from other sources for these expenses. I understand that all reimbursement received under this Plan will be paid directly to me and that I am responsible for any taxes or penalties that may arise in the event that I request and receive reimbursement that does not qualify for tax deductibility under federal or state law. I understand that I am required to file Form 2441 annually with the IRS to support my deductions for these expenses.

Employee Signature _____ Date _____

Mail to: Frates Benefit Administrators
13439 Broadway Extension, Suite 110
Oklahoma City, OK 73114
(405) 290-5696

Fax to: (405) 775-5992
Attention FLEX Claims

Frates Benefit Administrators

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