City of Austin
FLEXTRA Dependent Care Reimbursement Claim Form

Mail to: CompuSys/Erisa Group, Inc.
13706 Research Blvd Ste 308
Austin, TX 78750
Fax to: (512) 250-2937
Telephone: (512) 250-9397
(800) 933-7472

INSTRUCTIONS

1. Complete, sign and date this form. Mail or Fax this form and documentation to Compusys/Erisa Group—Austin.
2. Attach itemized documentation from the dependent care provider indicating the provider's name, address, tax identification number, dates of service (from-to), name of the dependent, services rendered and the amount paid.
3. If you do not have an itemized receipt, have the dependent care provider complete, sign and date Section C of this form.

SECTION A: EMPLOYEE INFORMATION (Please Print)

EMPLOYEE NAME (LAST, FIRST, MIDDLE) | SOCIAL SECURITY NUMBER | DATE OF BIRTH

MAILING ADDRESS | IS THIS A NEW ADDRESS? ☐ YES ☐ NO

CITY | STATE | ZIP CODE

WORK PHONE | HOME PHONE

SECTION B: DEPENDENT CARE INFORMATION (Please Print)

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	DEPENDENT CARE PROVIDER
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DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	DEPENDENT CARE PROVIDER

DATES OF SERVICE: FROM / / TO / / AMOUNT PAID $

SECTION C: SERVICE PROVIDER CERTIFICATION (To be completed by service provider as a receipt for services)

DEPENDENT CARE PROVIDER NAME | TAX I.D./SOCIAL SECURITY NUMBER

DATES OF SERVICE: FROM / / TO / / AMOUNT PAID $

NATURE OF SERVICE (i.e. day care, other school care, etc.) _____

PROVIDER SIGNATURE _____ DATE _____

SECTION D: EMPLOYEE CERTIFICATION (Read this section carefully; then date and sign this form.)

I want this reimbursement from my _____ FLEXTRA Dependent Care Account. **(Specify Plan Year)**

I certify that the charges attached or listed above are eligible dependent care expenses under the Internal Revenue Code, the charges have been incurred, and that I have not been reimbursed by, nor are these charges reimbursable by any other source. I also certify that I will not claim these charges as a credit on my personal income tax return. I understand that failure to submit claims with all required documentation by **MAY 31st** following the close of the Plan Year (March 15th) will result in my expenses not being reimbursed and I will lose any money left in my account. **Claims must be postmarked by MAY 31st.**

SIGNATURE _____ DATE _____

If funds are available in your account, checks are mailed by 5 p.m. Friday for claims received by Wednesday.