FLEXIBLE SPENDING PLAN
IRS Section 125

Please retain a copy of this information for future reference.

IRS Section 125 (Flexible Spending Reimbursement) is available to you as an employee benefit. Flexible spending allows you to pay for certain expenses through a pre-tax payroll deduction which can result in *significant* tax savings. Your flexible spending claims will be processed every Wednesday beginning January 7, 2015. Please be aware if the scheduled processing day falls on a holiday or weekend your claims will be processed one business day prior. Plan your flex submissions accordingly.

MEDICAL/DENTAL REIMBURSEMENT

Your medical/dental reimbursement plan will allow you to pay for out-of-pocket expenses with pre-tax dollars. For any tax-deductible health care expenses not covered by a health plan or other insurance, you simply complete a Flexible Spending Claim Form, attach the appropriate bills/receipts or explanation of benefits from your other insurance carrier, and send it to SISCO.

Tax deductible expenses include deductibles, copayments-payments, dental and vision expenses. If you are covered under more than one plan, you will need to file a claim attaching the explanation of benefits from all plans.

Automatic Rollover:

If you are enrolled in your company's health plan administered by SISCO, claims will automatically be reimbursed for ineligible health plan expenses, deductibles, and any copayments with your Flexible Spending Account for these expenses to rollover automatically without filing a separate flexible spending claim. You need only to elect the Automatic Payment Authorization Section once each year to receive reimbursement. Do not sign up for automatic rollover if you have coverage under more than one plan.

DEPENDENT CARE ASSISTANCE

Your dependent care expense plan allows you to pay for expenses that are incurred for the care (daycare, babysitting) of a qualifying dependent, or for related household services and are incurred for you to be gainfully employed. Submit a claim form for dependent care expenses actually incurred and you will be reimbursed from your Flexible Spending Account with pre-tax dollars that were deducted from your payroll.

The IRS requires that Form 2441 be filed with your Federal Income Tax Return, if you participate in a dependent care plan, listing the providers name, address, and social security or tax I.D. number.

Advantages of a Flexible Spending Account

A Flexible Spending Account (FSA) allows you to save up to 30% on your eligible healthcare and/or dependent care expenses every year by using pre-tax dollars. Consider how much you spend on healthcare and/or dependent care expenses for you and your qualified dependents in one year:

- Prescription drugs/medications
- Medical/dental office visit co-pays
- Eye exams and prescription glasses/lenses
- Vaccinations
- Daycare tuition

By using pre-tax dollars, you are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes, and thereby you increase your take home pay.

Pre-Tax Savings Example

Gross Monthly Pay	Without FSA	With FSA
	$3,500	$3,500
Pre-Tax Contributions		
Medical/Dental Premiums	$0	($125)
Medical Expenses	$0	($75)
Dedepndent Care Expenses	$0	($400)
Total	$0	($600)
Taxable Monthly Income	$3,500	$2,900
Taxes (federal, state, FICA)	($968)	($802)
Out of Pocket Expenses	($600)	$0
Monthly Take-home pay	$1,932	$2,098

Based on the above graph, adding a flexible spending account can increase your net take-home pay by $166/month. (This is for illustration only. Actual dollar amounts may vary.)

Frequently Asked Questions

- *Why do I want to participate?*
  - By signing a participating agreement, you agree to have your salary reduced by the agreed upon amount. Therefore, you are not responsible for federal income tax withholding or FICA on the amount of the reduction, thereby saving you 7.65% on FICA, plus whatever income tax you would be obligated to pay on this amount. While it's true that you forfeit unused money from your flexible spending account, you can still come out ahead even if you don't use all the money in your account.

- *When do I make my election?*
  - You need to make your election during open enrollment at your employer. This usually occurs once per year prior to the start of the new plan year. The start of the plan year may vary.

- *Can I change my benefit election mid-year?*
  - Medical reimbursement accounts can be changed with a qualifying event (i.e. marriage, divorce, death or a spouse or child, birth or adoption of a child, termination of employment of your spouse, or a change in work schedule). You may change your reimbursement election if you were enrolled in the plan prior to the qualifying event and you wish to change your election. Changes must be made within 31 days of the event.
  - Dependent care reimbursement accounts can be changed with a qualifying event (i.e. birth or death of a child, adoption of a child, dependent is no longer eligible for daycare, change in employment status thus changing the need for daycare, changing daycare providers, or a cost increase or decrease in daycare).

- *What happens if my reimbursement request exceeds the balance in my account?*
  - Your medical reimbursement account claims will be paid in full, up to the annual amount you have elected to have withheld for that plan year.
  - Dependent care reimbursement account claims will be processed and paid up to the balance in your account. If your claim exceeds that balance, SISCO will automatically reprocess your claims as your balance allows.
  - **Please note: the medical reimbursement account is separate from the dependent care account. Balances cannot be transferred from one account to the other.**

- *What happens to the money in my account if I should terminate employment?*
  - **You would be entitled to reimbursement for expenses which were incurred within the same plan year and before your termination date.** Your plan allows you to submit claims up to 180 days after termination in the plan.

- *What happens to any money left over at the close of the plan year?*
  - **FSA funds do not rollover.** Any money left over in your account at the close of the plan year is forfeited to your employer. Take precautionary steps, such as tracking account balances on our online system or contacting our customer service department at 1-800-457-4726. You may also contact our flexible spending department via email at siscoflex@siscobenefits.com.

- *When can I incur claims?*
  - Your plan year allows you to incur claims from January 1, 2015 through March 15, 2016. Your plan has elected a voluntary benefit known as grace period. You are allowed to submit claims incurred two and a half months after the end of your plan year for payment in your previous year. For example, if your plan year ends on December 31, you can incur claims through March 15 of the following year but get reimbursed out of your prior plan year account.

- *What is the filing deadline for claims submission?*
  - The filing deadline varies depending on your plan. You have 90 days to submit claims at the end of the plan year. The last day to submit claims is March 31, 2016.

Flexible Spending Election Form

University of Dubuque # 012

January 1, 2015 through December 31, 2015
Plan Year 2015

Section I - Employee Information

Employee-Last Name First Name Initial	Date of Birth	Social Security Number	
Street Address / City		State	Zip Code

Type of Election: ☐ Annual Election ☐ New Hire ☐ Family Status change * see below

Explanation for change in Family Status ____

Effective date of this election (date of first paycheck with flexible spending reduction) ____________________

Pay Period: (Circle One) bi-weekly/monthly

Section II - Flexible Spending Agreement

I hereby elect to have my salary reduced and a corresponding amount credited to my account in the Plan. Any previous election and compensation reduction agreement under the Flexible Spending Account relating to the same benefits is hereby revoked. I have read and understand the Summary Plan Description.

☐ I authorize that my bi-weekly/monthly earnings be reduced in the amount of $__________ (12/26 deductions) for **other medical/dental expenses**, for a yearly contribution of $ __________ ($2550 maximum). These would be expenses incurred which the health plan does not cover (i.e., deductibles, copayments, etc.). I understand I will only need to complete the attached claim form (attaching my bill, receipt or EOB) to receive reimbursement for any items not processed through the University of Dubuque Health Plan, or if I am covered under more than one health plan.

******Automatic Rollover Payment Authorization******

☐ **I understand that this document is also a claim form for expenses processed through the University of Dubuque Health Plan and that any eligible amount unpaid will be rolled over to the University of Dubuque Flexible Spending Plan for reimbursement from my account.**

By checking this box, I verify that expenses automatically submitted to the University of Dubuque Flexible Spending Plan during the year are actual expenses for which I am liable and that these expenses are not eligible for reimbursement/payment under any other source. I agree to notify the Company immediately if I have reason to believe that any expense automatically rolled over does not qualify for reimbursement under the Flexible Spending Plan.

☐ I authorize that my bi-weekly/monthly earnings be reduced in the amount of $__________ (12/26 deductions) for **dependent care expenses**, for a yearly contribution of $__________ ($5000 maximum). I understand I will need to submit a claim form to receive reimbursement.

I agree to notify the Company if I have reason to believe that any medical care expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal and state income tax or Social Security tax from any reimbursement I receive on any non-qualifying expenses.

Employee's Signature Date	Accepted by Date

Section III - Declining Flexible Spending Coverage

I hereby waive participation in the University of Dubuque Flexible Spending Account Plan for 2015. I understand I will not be able to elect participation until the new plan year begins.

Employee's Signature Date	Accepted by Date

Eligible Healthcare Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return (without regard to the 1% and 5% of adjusted gross income limitations).

This is a list of common reimbursable and non-reimbursable items under Section 502 of the Internal Revenue Code. This does not constitute legal or tax advice. For specific questions please see your plan administrator.

Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Blood sugar test kits/test strips
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductible and co-insurance
- Diabetic supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses, prescription only (warranties are not reimbursable)
- Flu shots
- Hearing aids and hearing aid batteries (warranties are not reimbursable)
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments (Current rate is $0.235.)
- Nasal strips
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physicals
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Reading glasses
- Sales tax on eligible expenses
- Services connected with donating an organ
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Vaccinations
- Wrist supports, elastic wraps
- X-ray fees

OTC Medicines and Drugs

Purchases require a prescription or a letter of medical necessity from your physician for reimbursement.

- Bengay, Flexall, pain relieving creams or gels
- Calamine lotion
- Canker/cold sore relievers
- Cold medicines
- Corn removal
- Diaper rash ointment
- Gas-X, baby gas drops
- Hemorrhoid creams and treatments
- Hydrogen Peroxide or rubbing alcohol
- Indigestion or anti-acid relievers
- Laxatives
- Nicotine patch or gum
- Pain relievers (Tylenol, Advil, Aspirin, etc)
- Sinus medicines
- Suppositories

- Teething gel
- Wart removal medication

Dental Expenses

- Braces and orthodontic services (see orthodontia worksheet for more information on reimbursement)
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

For the Disabled

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books and magazines in excess of cost of regular editions
- Note-taker, cost of, for a hearing impaired child in school
- Seeing eye dog (buying, training and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/maintaining)

Potentially Eligible Expenses

Following are some expenses eligible only when incurred to treat a diagnosed medical condition. This type of expense requires a Letter of Medical Necessity from your physician to be submitted along with your request for reimbursement that contains the medical necessity of the expense, the diagnosed condition, the onset of the condition and the physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose
- Varicose vein treatment
- Veneers
- Wigs (for medical health condition of individual who loses hair because of a disease)

Ineligible Healthcare Expenses

- Athletic mouth guards
- Auto insurance providing medical coverage
- Chapstick/lip balm
- Contributions to state disability funds
- Cosmetic surgery, cosmetic dentistry or other cosmetic procedures
- Cosmetic supplies (make up, facial soaps/creams and moisturizers, etc)
- Deodorant
- Dental floss
- Diaper service
- Diet: special diets and/or cost of special foods taken as substitute for regular diet
- Dietary and fiber supplements
- Divorce: expenses of divorce when doctor or psychiatrist recommends divorce
- Distilled water purchased to avoid drinking fluoridated city water or for use in medical equipment
- Domestic help: payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature
- Electrolysis/hair removal
- Exercise equipment and fees
- Eye drops for general comfort
- Eyeglass cases
- Hand sanitizer
- Health club or athletic club membership fees
- Herbal supplements
- Illegal treatment or medication
- Insurance premiums, all types
- Lanyards
- Lotions or skin moisturizers
- Marriage counseling
- Maternity clothes
- Mattress
- Medicare premiums
- Medicated shampoos, conditioners, and soaps
- Mobile telephone used for personal calls as well as calls to physician
- Nursemaids or practical nurses who render general care for healthy infants
- OTC drugs/medications without a prescription (effective January 1, 2011)
- Pajamas/slippers purchased to wear in hospital
- Personal use items (toothbrush, vacuum, pillow, shampoo, mattress, etc)
- Physical treatment unrelated to specific health problems (massage for general well-being, stress, depression, or chiropractic wellness program)
- Premiums for coverage through other medical plans (i.e., spouse's employer-sponsored plan or individual plan)
- Private hospital rooms
- Safety glasses (non-prescription)
- Special foods purchased to replace nutrition or for general health needs, such as diet foods.
- Sun Glasses (non prescription) and Sun Clips
- Teeth whitening
- Toiletries
- Toothbrush (includes prescribed electric ones)
- Toothpaste
- Vacuum cleaner purchased by an individual with dust allergy
- Vitamins and/or supplements
- Warranties
- Weight loss drugs/programs for general well being

Instructions for filing a Flexible Spending Claim

1. Complete Participant Name and Member Identification Number at the top of the front page.

2. Complete Health Care and/or Dependent Care expense section as appropriate.
   → Attach all required supporting documentation.

   Supporting Documentation

   The type of documentation described under either A or B below must be attached to the completed form.

   A. Explanation of Benefits (EOB): This is the form you receive each time you or a health care provider submits claims for payment to your health, dental, or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by health, dental, or vision plans, you must attach an EOB.
   B. Receipts: Claims for Dependent Care Expense and medical/dental expense not covered by your group health plan will not be processed without acceptable evidence of your expenses. Acceptable evidence includes receipts, which contain the following information:

      - Description of service or supply
      - Date expense was incurred
      - Person or organization providing service
      - Amount of expense
      - Name of person for whom the service(s) provided

A canceled check is not considered acceptable evidence.

3. Sign and date the Flexible Spending Reimbursement Form at the bottom of the front page.

4. Mail the completed form and attachment(s) to the address indicated on the bottom of the front page.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Reimbursement of dependent care expenses will reduce and may eliminate completely your ability to claim dependent care credit on your Federal Tax Return.
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on your Federal Income Tax Return.
- Health care expenses reimbursed through this account cannot be deducted on your Federal Income Tax Return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible dependents under the plan.
- Only the expenses for services or supplies furnished on or after the effective date of the plan can be submitted for reimbursement.
- Reimbursement of expenses should only be requested and made after you have collected all benefit payments available for all other plans under which you and your eligible dependents are covered.
- Reimbursement will only be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

University of Dubuque # 012

MEDICAL REIMBURSEMENT FORM

Claims must be received at SISCO, two (2) business days before your scheduled flexible spending run.

Participant Name______________________________ Participant ID #___________________

MEDICAL/DENTAL/VISION EXPENSES -- ATTACH EOBS OR RECEIPTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or from any other source.
- All health care expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Packet

(Signature)____ (Date) _____/_____/______

KEEP A COPY FOR YOUR FILES

MAIL TO:

ATTENTION: Flexible Spending Dept., SISCO, P.O. Box 389, Dubuque, IA 52004-0389

Fax: 563-587-5703

Email: siscoflex@siscobenefits.com

University of Dubuque # 012

DAYCARE REIMBURSEMENT FORM

Claims must be received at SISCO, two (2) business days before your scheduled flexible spending run.

Participant Name______________________________ Participant ID #___________________

DAYCARE EXPENSES – ATTACH STATEMENTS TO CLAIM FORM

Item	Dependent Name	Date(s) of Service	Provider (Person or Business)	Reimbursement Requested
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

*Dependent Care Expenses - If the amount of the above expenses exceeds the balance in your account, do not resubmit for the unreimbursed portion on this claim. You will automatically be reimbursed as your account balance allows.

I hereby certify that:

- The information given on this reimbursement form is complete and accurate.
- I have not previously received reimbursement for these expenses from this Flex account or from any other source.
- The total of reimbursed dependent care expenses does not exceed the lesser of my spouses or my earned income (W-2 Pay) for the year, if less than $5,000.
- All dependent care expenses listed above comply with the requirements and guidelines listed in the Flexible Spending Packet

(Signature)____ (Date) ____/_____/______

KEEP A COPY FOR YOUR FILES

MAIL TO:

ATTENTION: Flexible Spending Dept., SISCO, P.O. Box 389, Dubuque, IA 52004-0389

Fax: 563-587-5703

Email: siscoflex@siscobenefits.com

Orthodontia Worksheet Instructions

The treatment of orthodontic expenses under a Medical Flexible Spending Account (FSA) is different than other medical expenses because services generally span more than one Plan Year. Under IRS regulations the service must be reimbursed from the same FSA Plan Year in which the services were provided and the service must have been incurred. Nevertheless, IRS officials have informally commented that a pre-payment of orthodontia expenses is permissible in certain instances. Below are the various options for reimbursement of orthodontic services, instructions on how to submit a reimbursement request for orthodontic expenses and instructions on completing the Orthodontia Worksheet.

If a service agreement or contract has been drawn between the orthodontic provider and participant agreeing on services provided and payments due over the course of the treatment, the participant is reimbursed on a monthly basis according to the agreement. Reimbursements for these payments may span over one or more FSA Plan Years, as per the agreement. For example, if the agreement indicates a one-time payment of $500 upon placement of the braces and a monthly fee of $50 thereafter for 2 years, the amounts eligible for reimbursement are those incurred within each Plan Year (up to your current remaining balance). Pre-payments of monthly fees are not reimbursable as the service must be provided and payment must have a due date within your Plan Year coverage period. (Payments due in one Plan Year cannot be reimbursed from the next Plan Year.)

If full payment is required by the orthodontic provider before services can begin, the total cost for the treatment is eligible for reimbursement when the work is started and the payment is made. A one-time reimbursement for the total cost of the treatment up to your current available balance may be made from your current Plan Year Medical FSA. For example, if a full payment of $3,000 is required at time of placement and your current Medical FSA balance is $2500, you are eligible to be reimbursed for $2500.

If the orthodontic provider does not offer the options above, complete the Orthodontia Worksheet to determine the monthly amount that may be eligible for reimbursement from your Medical FSA.

Loan payments and interest on a loan are not eligible expenses. Complete the Orthodontia Worksheet if no other receipt or contract is available from the orthodontic provider.

Submitting orthodontia expenses for reimbursement:

- A Request for Reimbursement Form must be completed each time you want to be reimbursed.
- With each Request for Reimbursement, include a copy of the orthodontic contract, coupon (if provided a payment book) or itemized receipt. All documentation must clearly indicate the month and year of the service provided (or payment due date), the monthly payment amount, the name of the provider and a description of the service (orthodontia, braces, placement or banding fee).
- In the absence of a contract or service agreement:
  - Complete the Orthodontia Worksheet
  - Have it signed by your orthodontist;
  - Submit with each Request for Reimbursement.
- Initial payments, banding or placement fees are eligible for reimbursement upon placement. An itemized receipt must accompany the Request for Reimbursement Form that indicates the service is a banding or placement fee instead of a monthly fee.
- A Request for Reimbursement of payment in full for orthodontic treatment at the start of the orthodontic services requires an itemized receipt from the orthodontic provider to accompany the Request for Reimbursement.

In the absence of a contract or service agreement the orthodontic provider must apportion the total cost of the treatment, less the initial payment due and any payments expected from your insurance company or provider discounts to the remaining number of months required for treatment. This will determine the monthly payment amount eligible for reimbursement from the Medical FSA. Once the form is completed, we can set up automatic reimbursement payments based on the information provided on the form.

- Enter the total cost for the duration of the treatment in the *Total Cost* section in below.
- Enter in any insurance payments and provider discounts.
- Enter the estimated portion of the total cost that is apportioned to the services provided in the first visit (when the braces are applied) in the *Initial Payment Due* section. (Generally one-third or less of the total cost.)
- Subtract the insurance payments, provider discounts and initial payment due from the total cost and enter this amount in the *Total Remaining Balance* section.
- Enter the number of months the treatment is expected to continue after placement of the braces.
- Divide the Total Remaining Balance by the number of months and enter this amount in the *Monthly Payment* section. This is the amount eligible for reimbursement from the FSA on a monthly basis.

Participant Name ____________________ Participant 9-Digit ID# ______________________

Employer___________________________ Employer Group Number ____________________

Patient Name________________________ Date Treatment Begins ______________________

Total Cost for Orthodontia Services $____________

<u>Subtractions</u>

Insurance Payments: $____________

Provider Discount: $____________

Initial Payment: $____________

Total Remaining Balance: $____________ / ______________ = [ ]

(Length of Treatment) **Monthly Payment**

Signature of Provider ___________________________________

Printed Name of Provider ________________________________ Date _________________

Dependent Care Contract Instructions and Form

Following is a Flex Spending/Dependent Care Contract form. Please complete the form and submit with a Dependent Care Flexible Spending Claim form. You will only need to complete this contract and claim form one time. Upon receipt, your dependent care claims will be processed according to the information submitted and no further receipts or claims will be required. **This contract allows for automatic reimbursement of your dependent care funds as your balance allows.**

(This Dependent Care Contract needs to filled out yearly if you would like to take advantage of automatic reimbursement of your dependent care funds without having to submit claim forms and receipts each time)

If you have a change in your dependent care, such as rate or provider changes, you will need to submit a new Claim Form and Contract. Upon receipt of the updated information, we will again process dependent care charges without requiring further receipts or claim forms.

We hope that you will take advantage of this convenient service offer by SISCO and your employer.

Please feel free to contact us at 800-457-4726 or siscoflex@siscobenefits.com if you have any questions regarding this or any other flexible spending option.

Company Contract

University of Dubuque # 012

January 1, 2015 through December 31, 2015

Terms of Contract

Employee Name: ______________________________ Participant ID #: ______________________________

My contract will begin on ____________________________, and end on ______________________________

This form is being submitted to establish that a contract for services exists between me and the individual/entity who has signed below in which I have agreed to purchase dependent care services for the period indicated.

Provider's Name: ____

Provider's Address____

City: _____________________ State: __________________ Zip: _____________

I/We agree to provide daycare services for the above mentioned employee.

The Current scheduled time period is _________________ A.M to __________________ P.M.

The Current Rate of Pay is $_______________________ (circle one) **Hourly** **Daily** **Weekly**

The above mentioned employee will be billed (circle one) **Daily** **Weekly** **Monthly**

Based on the above schedule, it is anticipated that the above mentioned employee will incur fees which will total, during the time period stated above, a minimum of

$ __________________________.

Provider's Signature: ____

Provider's Title: ____

Provider's SSN#, EIN#, or TIN#: ____

Date: ___________________________

Note: The IRS requires a W-10 form completed for all services provided.

If the terms of this contract were to change at any time, you will need to contact SISCO.