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, 2016 through December 31, 2016

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.