La Sierra UNIVERSITY

Payroll Office
4500 Riverwalk Parkway
Riverside, CA 92515
(951)785-2034

FSA

Flexible Spending Account

Dependent Care Expense
Complete Sections A, B, C and D

Health Care Expense
Complete Sections A and B

CLAIM FORM FOR (year): _____

Last Name, First Name: _____

Social Security #: _____ **ID #:** _____

A. List of Expenses

Check only one:

☐ DEPENDENT CARE (Attach paid bills, receipts, cancelled checks or other evidence of these expenses)

☐ MEDICAL/DENTAL (Attach Explanation of Benefits form and Paid Receipts for Deductible and Coinsurance)

Date of Service	Payment Made To	Service Provided	Amount	Insurance Paid	Your Portion

B. Spouse and Dependent Information

If expenses were for your spouse or for a dependent:

Person's Name Birthdate Relationship

C. Other Dependent Care Information

☐ Check here if you have no spouse

Spouse's expected earned income this year:

☐ Less than $5000. Specify amount $ _____

☐ More than $5000.

TOTAL Reimbursable EXPENSES: $ _____

D. Tax Information For Dependent Care Expenses

Name & Address of Person Providing Care	Social Security# or Tax ID # of Provider

Federal law and Internal Revenue Service regulations require that the above information be provided for Dependent/Child Care claims.

PAYROLL USE ONLY

Date Claim Entered _____

Claim #	$ Amount Paid	Check #	Check Date

I certify that the expenses listed above have been incurred and paid by me and qualify for reimbursement. The paid bills, receipts, cancelled checks, or other evidences of these expenses are attached.

Signature _____ Date _____