Dependent Care FSA Expense Claim Form

Employee Data

Company Name: Nutanix, Inc.

Employee Name:

Employee ID (Last 4 of SSN):

Dependent Information (complete once per year for each dependent)

Full Name	Date of Birth	Relationship to Employee

Provider Receipt

Additional receipts are not necessary if the below section is completed by the dependent care provider. In lieu of the child care provider's signature below, you may submit a receipt from the provider to substantiate this claim.

Provider Name:		Provider Tax ID Number:
Explanation of Care Provided:		
Name of Dependent	Dates of Care	Charge for Care
	From: To:	$
	From: To:	$
	Total	$

I certify that dependent care was provided to above referenced dependents on the dates indicated. The charges for care reflect dependent care for the dates indicated.

Date	Provider Signature	Printed Provider Name

Verification

To the best of my knowledge and belief, the statements in this dependent care expense claim form are complete and true. I certify these claims are for valid dependent care expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the Vita Flex Dependent Care Reimbursement Plan, and that these expenses are incurred by an eligible participant under the plan (either myself as the eligible employee or an eligible dependent according to the guidelines of the plan). *These expenses have not been reimbursed under the Vita Flex plan previously nor have they been reimbursed under any other dependent care plan. Additionally, I do not expect any of these expenses to be reimbursable elsewhere in the future.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

Date Employee Signature

New Phone/Address (Complete Only if Needed)

New Email Address:

New Home Address:

Online:
www.vitaflex.net

Fax:
Vita Flex Claims Dept.
(650) 964-FLEX (3539)
(866) 964-FLEX (3539)

E-mail:
claims@vitamail.com

Mail:
Vita Flex Claims Dept.
900 North Shoreline Blvd.
Mountain View, CA 94043