SHEAKLEY FLEXIBLE BENEFITS

Dependent Care Claim Form

PART 1: Employee Information

Employee Name: (First) _____ (Last) _____

Social Security Number: _____ - _____ - _____ Work Phone: _____

Employer Name: _____ Email Address: _____

PART 2: Address Change ***(Only complete this section if you have had a change in address)***

Address: _____, _____, _____, _____

PART 3: Employee Certification for Reimbursement

The expenses listed below were incurred by my dependent(s) in order for myself and my spouse to remain gainfully employed or attend school full time. The expenses incurred are not for tuition or school fees designated for educational purposes. The amount I claim for Dependent Care reimbursement may not exceed the maximum calendar year limit of $5,000 per family or $2,500 if married and filing separately. I understand that expenses reimbursed may not be used to claim any federal income tax deduction or credit, such as the Dependent Care Tax Credit. I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature ***(required)***: _____ Date: _____

PART 4: Provider Certification

I certify that we are providing Child Care Services for the above employee for the period(s) of time listed below.

Provider Signature ***(required if no receipt attached)***: _____ Date: _____

Dependent Names/Ages ***(required)***: _____ / _____ _____ / _____

_____ / _____ _____ / _____

Name of Provider/Entity ***(required)***: _____

Federal Tax ID or Social Security Number ***(required)***: _____

PART 5: Itemized List of Expenses

Date of Service ***(required)***	**Amount** ***(required)***
to	$
to	$
to	$
to	$
to	$

Total Amount Requested ***(required)***: **$**_____ (Minimum Claim Amount: $25.00)

****Any required items not completed may result in delayed reimbursement.****

Attach and submit copies of all supporting documentation for the items listed above. Incomplete forms will be denied for additional information. Account information and verification of claim receipt is available at www.myrsc.com. Please allow 24 to 48 hours after faxing to verify receipt. Customer Service is available 8:00am to 5:00pm Eastern Standard Time Monday through Friday toll free at 800-877-6630. To set up direct deposit, if applicable to your Plan, please contact Sheakley for appropriate forms.

FOR QUICKEST REIMBURSEMENT, FAX TO 513-326-8082 OR EMAIL TO 125@SHEAKLEY.COM

Claim forms can also be mailed to: Sheakley Flexible Benefits Division
One Sheakley Way
Cincinnati, OH 45246