



**MONTHLY DEPENDENT CARE CLAIM FORM**

**Part 1: Employee Information:**

Employee Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Part 2: Address Change Section: (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 me (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 under the Dependent Care Reimbursement may not exceed the maximum calendar year per family of \$5,000, or \$2,500 if married filing separately. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Credit). I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon.

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 \_\_\_\_\_ Date \_\_\_\_\_

**Part 4: Provider Certification**

I certify that we are providing Child Care Services for the above employee for the month of \_\_\_\_\_ in the year of \_\_\_\_\_ as shown below. (Only needed if you do not have supporting documentation.)

Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

Dependent Names/Ages \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Provider/Entity \_\_\_\_\_

Federal Id # or Social Security Number: \_\_\_\_\_

	<u>Service Date</u>	<u>Amount</u>
Week 1	____/____/____ to ____/____/____	\$ _____
Week 2	____/____/____ to ____/____/____	\$ _____
Week 3	____/____/____ to ____/____/____	\$ _____
Week 4	____/____/____ to ____/____/____	\$ _____
Week 5	____/____/____ to ____/____/____	\$ _____
<b>Total Requested Amount</b>		\$ _____

Dependent Care Claims are reimbursed to the participant up to the balance available in the account. Incomplete forms will be denied requesting additional information. Account information is available at [www.myrsc.com](http://www.myrsc.com). Please allow 24 to 48 hours after faxing to verify receipt. Customer Service is available 8:00 a.m. to 5:00 p.m., Eastern Standard Time toll free at 800-877-6630. **To set up direct deposit (if applicable) attach a voided check with your first claim.**

**FOR QUICKEST REIMBURSEMENT FAX TO 513-326-8082**

Or mail to: Sheakley UniService, Flex  
P.O. Box 42212 . Cincinnati . OH . 45242