Dependent Care Expense Claim for Reimbursement

Employer _____

Name _____ Member ID _____

Name Of Dependent(s)	Period Covered From To	Name, Address and Tax Identification Number of Provider of Service	Amount Incurred
		TOTAL DEPENDENT CARE EXPENSE CLAIM	$0.00

I certify that the dependent care services listed above have been provided by me and expenses in the amount listed above have been incurred by the Plan participant for such services.

Signature of Provider of Service _____ Date _____

*NOTE The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Employer's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature _____ Date _____

Please mail completed form and required documentation to:	Rose & Kiernan, Inc. 99 Troy Rd East Greenbush, NY 12061 Fax # 518-244-4261

To expedite your claim in a timely manner, PLEASE SUBMIT ALL RECEIPTS ON 8.5" X 11" PAPER

This form can be accessed at www.rkinsurance.com