

HOW TO REQUEST REIMBURSEMENT FROM YOUR DEPENDENT CARE ACCOUNT

This form is to be used only to request reimbursement for dependent care expenses. To view a detailed list of eligible dependent care expenses, visit www.myshps.com. In general, and subject to the rules of your employer's plan, the following rules apply to dependent care expenses:

- The individual receiving care must be either a qualifying child or a qualifying relative. (see below for IRS definition of dependent)
- The individual must be under the age of 13 unless he or she is physically or mentally unable to care for himself or herself.
- The expenses must be incurred so that you and your spouse, if married, can work or your spouse can attend school on a full-time basis.
- Child care or elder care centers must comply with all applicable state and local laws in order for dependent care expenses to be reimbursed.
- The annual amount of dependent day care claims cannot exceed your annual deposit amount up to (a) \$5,000, (b) \$2,500 if married and filing separate returns, or (c) your or your spouse's annual salary, if less than \$5,000.

Step 1: Fill out the form

- Please print in capital letters, with your letters centered in the boxes provided and fill in all ovals as shown:

A	B	C	D		1	2	3	4
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YES NO

- For Section 2 & 5: Complete a separate line for each individual expense. Do not lump expenses together.
- Complete all sections of the form. Sign and date the bottom of the form.
- If your expenses exceed the number of lines provided, please use page 3 for additional claim.

Step 2: Attach supporting documentation

- Copy your receipts or other supporting documentation onto a white, letter-sized sheet of paper. Place your receipts so they all face the same direction. And write your Social Security Number or employee ID at the top of the page.

Step 3: Submit your form (Faxing is faster)

- By Fax: Send the form and copied receipts together as one fax. Do not include a fax cover sheet.
- By Mail: Place the form and the supporting documentation into an envelope, apply the correct postage, and mail.
- If you provide your e-mail address, SHPS will e-mail you confirmation we received your form.
- Keep a copy of your completed form and receipts for you records.

Step 4: Receive your reimbursement (Direct Deposit is faster)

- By using Direct Deposit or Electronic Funds Transfer (EFT), you'll receive your reimbursement funds up to five days faster than by receiving a check. To sign up, log in to your account at www.myshps.com and select "Direct Deposit Sign-Up" from the left-side menu.

Type of Supporting Documentation:

You must include supporting documentation for your dependent care expenses with your claim. Attach a copy of the bill or signed receipt, or have the provider sign the Affidavit on Section 2 of the claim form. Claims without the Tax ID number for all providers will be denied. If your provider is tax exempt, enter all 9s in the Provider's Tax ID.

Please Do NOT:

- Use red ink
- Use a photocopy of the form
- Highlight receipts or any part of the form
- Staple your copied receipts to the form
- Write outside the boxes provided
- If faxing, fax the same form more than once
- Mail the same form that you have faxed
- Include this instruction sheet with your fax
- Submit expenses for multiple plan years on the same form

New IRS Tax Dependent Definition:

A recent change to the Internal Revenue Code revised the definition of "dependent." Generally speaking, a qualifying child must reside with you for more than half the year and must not provide over half of his/her own support. A qualifying relative is an eligible individual if (1) you provide more than half of the individual's support, and (2) the individual is not a qualifying child of you or any other taxpayer.

Please note that any questions regarding the status of an individual as either a qualifying child or a qualifying relative must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's plan.

SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

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EMPLOYEE LAST NAME

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EMPLOYEE HOME ZIP CODE

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SECTION 5: YOUR ADDITIONAL DEPENDENT CARE EXPENSES

EXPENSE 2

START DATE OF SERVICE (MMDDYY)

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PROVIDER TAX ID OR SSN (ENTER ALL 9's IF TAX-EXEMPT)

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REQUESTED AMOUNT (DOLLARS . CENTS)

\$

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END DATE OF SERVICE (MMDDYY)

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RECEIPT ATTACHED? YES NO

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

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DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

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DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

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DEPENDENT #3 NAME _____

AFFIDAVIT:

Your day care provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt. I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____

DATE _____

EXPENSE 3

START DATE OF SERVICE (MMDDYY)

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PROVIDER TAX ID OR SSN (ENTER ALL 9's IF TAX-EXEMPT)

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REQUESTED AMOUNT (DOLLARS . CENTS)

\$

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END DATE OF SERVICE (MMDDYY)

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RECEIPT ATTACHED? YES NO

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

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DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

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DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

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