



DEPENDENT CARE SPENDING ACCOUNT CLAIM FOR REIMBURSEMENT



Name of Employer _____

Employee Name _____ Social Security _____

Employee Address _____

Street City

State Zip

Dependent Name Date of Birth Relationship to Employee

Three rows of horizontal lines for dependent information.

Please complete the information below and attach corresponding bills or receipts with dates of service for each listed provider.

Name: _____ Name: _____

Address: _____ Address: _____

Tax I.D. or Soc. Sec. # _____ Tax I.D. or Soc. Sec. # _____

Dates of Service: _____ to _____ Dates of Service: _____ to _____

If dependent care was provided in your home, complete the following:

Household Services Relating To The Care Of A Qualifying Individual (s) \$ _____
FICA And FUTA Taxes on Wages Paid To A Housekeeper \$ _____
Room And Board Expenses Incurred Outside The Home For A Housekeeper \$ _____
Transportation Expenses of A Housekeeper \$ _____
Other (please list) \$ _____

If your eligible expenses were incurred outside of your home, complete the following:

Services Related To The Care Of Qualified Individual(s) And Incurred in A Day Care Provider's Home/Day Care Center \$ _____

TOTAL DEPENDENT CARE REIMBURSEMENT REQUESTED: \$ _____

CERTIFICATION

I certify that I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account. I further declare that I have not and will not deduct these expenses on my Individual Income Tax Returns. I certify that the above eligible expenses have been (or will be) paid for the care of a qualified individual(s).

EMPLOYEE SIGNATURE _____ DATE _____

MAIL COMPLETED FORM TO:

FBA OF SYOSSET, LLC
100 QUENTIN ROOSEVELT BLVD, SUITE 502
GARDEN CITY, NY 11530
PHONE (855) 374-6431, FAX (888) 371-3151