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**
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____ Tax I.D. or _____

Soc. Sec. #_____ 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 403
GARDEN CITY, NY 11530
PHONE (855) 374-6431, FAX (833) 930-1024
WWW.FBANATIONAL.COM
Claims@fbaofsyosset.com