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 502
GARDEN CITY, NY 11530
PHONE (855) 374-6431, FAX (888) 371-3151