# 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: ____________________

Address: ____________________

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

Dates of Service:________ to ________

Name:____________________

Address: ____________________

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

Dates of Service: ________ to ________

<u>If dependent care was provided in your home, complete the following:</u>

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)

____________________________ $________

____________________________ $________

____________________________ $________

<u>If your eligible expenses were incurred outside of your home, complete the following:</u>

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**