

DEPENDENT CARE SPENDING ACCOUNT CLAIM FOR REIMBURSEMENT



Name of Employer Plainview-Old Bethpage Central School District Employee Name Social Security Employee Address Street City Zip State Date of Birth **Dependent Name** 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 _____ 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

MAIL COMPLETED FORM TO:

FBA OF SYOSSET, LLC 100 QUENTIN ROOSEVELT BLVD, SUITE403 GARDEN CITY, NY 11530 PHONE (855) 374-6431, FAX (833) 930-1024 WWW.FBANATIONAL.COM