

**DEPENDENT CARE SPENDING ACCOUNT
CLAIM FOR REIMBURSEMENT**

Employer Name: _____

Employee Name: _____ SS# _____

Street Address: _____

Street _____ City _____

State _____ Zip _____

Dependent Name	Date of Birth	Relationship to Employee
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

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

Name: _____

Name: _____

Address: _____

Address: _____

Tax ID or Soc. Sec. #: _____

Tax ID or Soc. Sec. #: _____

Dates of Service: _____

Dates of Service: _____

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

Household services relating to the Care of a Qualifying Individual(s):	\$	_____
FICA & FUTA Taxes on Wages Paid to a Housekeeper:	\$	_____
Room & 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 a Qualifying 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: _____

COMPLETE & RETURN TO:

FITZHARRIS & COMPANY, INC.

PO BOX 9182
FARMINGDALE, N.Y. 11735
(516) 777-2244 - FAX: (516) 777-5777 / 78