

**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 Soc. Sec. #: \_\_\_\_\_

Tax I.D. or 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	\$ _____
<b>TOTAL DEPENDENT CARE REIMBURSEMENT REQUESTED:</b>	\$ _____

**CERTIFICATION**

I certify that I an/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:**

**FITZHARRIS & COMPANY, INC.**  
PO Box 9182  
Farmingdale, NY 11735-9182  
(516) 777-2244 1-800-321-1336  
Fax (516) 777-5777/78