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 NATIONAL
100 QUENTIN ROOSEVELT BLVD, SUITE 403
GARDEN CITY, NY 11530
PHONE (855) 374-6431, FAX (833) 930-1024
WWW.FBANATIONAL.COM

10/2020