

# Request for Dependent Care Reimbursement Expenses

**Return completed form to:**  
**J.J. Stanis & Company, Inc.**  
 377 Oak St, Suite 406  
 Garden City, NY 11530  
 Fax Number 516 465 3920

Employer _____	Group Number _____
Employee Name _____	Member ID# _____
Last                      First                      Middle	
Home Address: _____	
Number/Street	City                      State                      Zip
<input type="checkbox"/> Please check only if this is a new address.	Daytime Telephone Number _____

### DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

You may complete the reverse side of this form and obtain your dependent care provider's signature verifying charges, or you must submit a receipt or statement from the provider giving the from-and-to dates of service. **IMPORTANT:** You must provide the IRS with the name, address and Tax I.D. (or Soc. Sec. No.) of the dependent care provider on your federal income tax return. If you are unable to provide this information, the tax exclusion for the dependent care reimbursement account may be denied by the IRS.

Date of Service From mo/day/year to mo/day/year	For the Benefit of (Name, Relationship, Date of Birth)	Provider of Service	Requested Amount
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

**TOTAL \$** \_\_\_\_\_

**Please provide the child care provider's tax identification number here:** \_\_\_\_\_

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you have questions about a claim, or the FSA program, please call **(877) 470-3715** between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.

**To access additional claim forms, please visit our website: [www.jjstanisco.com](http://www.jjstanisco.com)**

Employer _____	Group Number _____
Employee Name _____	Member No. _____
Last                      First                      Middle	
Dependent Name _____	
Home Address: _____	
Number/Street                      City                      State                      Zip	

**VERIFICATION OF DEPENDENT CARE SERVICES/CHARGES**

**Provider of Service:** \_\_\_\_\_

I certify that the charges listed on the reverse side for dependent care services have been incurred for the dates shown.

\_\_\_\_\_  
*(Signature of Provider)*

\_\_\_\_\_  
*(Date)*

**VERIFICATION OF DEPENDENT CARE SERVICES/CHARGES**

**Provider of Service:** \_\_\_\_\_

I certify that the charges listed on the reverse side for dependent care services have been incurred for the dates shown.

\_\_\_\_\_  
*(Signature of Provider)*

\_\_\_\_\_  
Date