Request for Dependent Care Reimbursement Expenses

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

Employer ______________________________ Group Number ______________

Employee Name ______________________________ SS No. ______________
Last First Middle

Home Address: ____
Number/Street City State Zip

☐ 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-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 and Relationship)	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

Employer ______________________________ Group Number ____________

Employee Name ______________________________ SS 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)

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