J.J. STANIS AND COMPANY, INC
377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530
PHONE: (516) 465-3900 FAX#: (516) 465-3920 WEBSITE: WWW.JJSTANISCO.COM

Request for Dependent Care Reimbursement Expenses

Return completed form by Mail, E-mail: claims1@jjstanisco.com, or Fax

Employer _____ Group Number _____

Employee Name _____ Member ID # _____
Last Middle First

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-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.

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Request for Dependent Care Reimbursement Expenses - Page 2

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Employee Name ______________________________ Member ID # ____________________
Last Middle First

Home Address ____
Number/Street City State Zip

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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)

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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.

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(Signature of Provider)

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(Date)
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