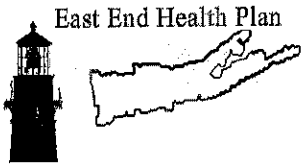
Request for Dependent Care Reimbursement Expenses

Return completed form to:
J.J. Stanis & Company, Inc.
100 Jericho Quadrangle Suite 101
Jericho, NY 11753
Fax Number – 1-516 465 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

For Administrative Use Only: Initials _____ 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)

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)

For Administrative Use Only: Initials _____ Date _____