

**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 \$ _____

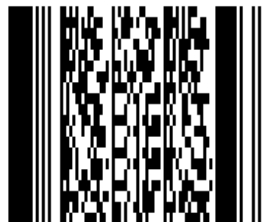
TOTAL DEPENDENT CARE REIMBURSEMENT REQUESTED: \$ _____

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: **BROWN & BROWN of NEW YORK, INC**
DBA FITZHARRIS & COMPANY
333 Earle Ovington Blvd Suite #215
Uniondale, NY 11553-3624
Phone (516) 944-2823, New Direct Fax# (978) 856-6042



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