Please send this form to:
FBA of Syosset
100 Quentin Roosevelt Blvd. Suite 502
Garden City, NY 11530
1-855-FRINGE1
claims@fbaofsyosset.com
888 371-3151 Fax

FBA Account Claim Form

Personal Information

Full Name: ____

Employer: ____

Social Security Number: ____

Phone Number: (   ) ____________________ E-mail: ______________________

If your address has changed please list the new address below.

New Address: ____

City, State, Zip: ____

Claim Information

Please complete the following information if you are not able to get a receipt from your transit or daycare provider.

Type of Expense: ______________________________ Amount: ______________

Type of Expense: ______________________________ Amount: ______________

Type of Expense: ______________________________ Amount: ______________

Type of Expense: ______________________________ Amount: ______________

Type of Expense: ______________________________ Amount: ______________

Type of Expense: ______________________________ Amount: ______________

Dependent Care of Transit Certification

Please complete the following information if you are not able to get a receipt from your transit or daycare provider.

____

Provider Name *Service Start Date* *Service End Date*

Dependent Care Only: ____

Provider Tax ID# *Provider Signature*

Employee Signature: ____

Date: ____

- By signing this form I agree to have my account reduced by the amount requested.
- This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- If additional information is required you will receive a denial letter letting you know what additional information is needed.
- Claims incurred during a grace period will be paid out of the prior year first.
- Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact you employer to see if advance payments for orthodontia expenses are allowed