



FSA Administration
 2601 Lac De Ville Boulevard
 Rochester, New York 14618
 Phone (585) 427-2010 Fax (585) 427-2293

Section 125 FSA - AFFIDAVIT OF DEPENDENT CARE COSTS

Employer Name: _____

EMPLOYEE INFORMATION

Social Security Number: _____
Employee Name: _____
Address: _____
City/State/Zip Code: _____
Department: _____

Hire Date: _____
Effective Date: _____
Sex: Male Female
Date of Birth: _____
Home Phone #: _____
Alternate Phone #: _____

List all dependents covered by this affidavit:	
1.	
2.	
3.	
4.	
5.	

Calendar Year for Dependent Care Costs: _____

Provide the Monthly and Annual Total of Dependent Care Costs for the above Calendar Year:

January	\$	July	\$
February	\$	August	\$
March	\$	September	\$
April	\$	October	\$
May	\$	November	\$
June	\$	December	\$
		Annual Total:	\$

I, the undersigned Day Care Provider or Administrator, certify that the above costs are accurate for the dependent(s) of the above named employee. I also certify that the dependents are under the age of 13 and are eligible for reimbursement under a Flexible Spending Plan.

Provider's Name: _____ **Tax ID #:** _____

Provider's Signature: _____

I certify that the above expenses are accurate at this time. I also certify that if the expenses change at any time during the plan year, it is my responsibility to notify USA Payroll FSA Administration regarding the changes.

Employee Signature: _____ **Date:** _____