

City of Newton
Flexible Spending Account (FSA)
DEPENDENT CARE CERTIFICATION FORM

Automatic Payment

EMPLOYER: CITY OF NEWTON PLAN YEAR: _____

EMPLOYEE: _____ SS#: _____ - _____ - _____

PLEASE PRINT

DEPENDENTS ELIGIBLE FOR FSA REIMBURSEMENT (Must be under age 13 or physically or mentally incapacitated-as defined by the IRS guidelines).

Name	Relationship	Date of Birth		Name	Relationship	Date of Birth

Names(s) of Day Care Facility or Individual who provides care:

Name:	Name:
Address:	Address:
Corporate or Individual Tax ID:	Corporate or Individual Tax ID:

Are you married (as defined by IRS)? Yes No

If married: Is your spouse employed? Yes No

If your spouse is NOT employed, is he/she:
Full-time student during the period of this claim? Yes No
(Note: Full-time student = 5 months)

If your spouse is NOT employed, is he/she
Disabled and unable to care for dependents? Yes No

PARTICIPANT'S SIGNATURE; _____

DATE: _____