LOST CHECK CLAIM

STOP NUMBER _____

Reset Fields

STATE OF NEW YORK
COUNTY OF NEW YORK

I, _____, being duly sworn do hereby say that Check Number _____ for $ _____ dated ____/____/____ and made payable to, _____ located at _____,was never received or was received and subsequently lost.

Check one:

- ❑ Dependent Care Assistance Program (DeCAP)
- ❑ Health Care Flexible Spending Account (HCFSA)
- ❑ Management Benefits Fund (MBF)
- ❑ Other:(Specify) _____

Describe Circumstances of Loss in Detail (Attach additional page if necessary)

I have not sold, assigned or transferred said check, or amount due thereon, to any person or party whatsoever. I have not received cash or other consideration for said check and I am still the sole owner of and entitled to receive the full amount thereof.

I make this affidavit to induce the issuance to me of a duplicate check to take place of, and in the same amount as, the missing one; should said missing check, at any time, come into my hands, I will immediately deliver it to the Flexible Spending Accounts Program/Management Benefits Fund Administrative Office at 22 Cortlandt Street, 28th Floor, New York, New York 10007.

I understand that if I present the original check for payment, and it is paid, the Office of Labor Relations reserves all of its rights and remedies, including the right to offset the amount from any account.

Signature _____ Date ____/____/____

Statement of Notary

State of)
) ss.:
County of)

On _____ before me, the undersigned, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on this instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
(Signature and office of individual taking acknowledgment)

Submit your completed form(s) electronically to:
https://nyc-fsa.leapfile.net

DO NOT WRITE BELOW THIS LINE

APPROVED:

_____
Flexible Spending Accounts Program and
The Management Benefits Fund Administrative Office

_____
OLR Financial Management

Print Form