

REQUEST FOR REFUND  
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES  
AGENCY FOR PERSONS WITH DISABILITIES  
Human Resources, Headquarters  
(Check One)

Date: \_\_\_\_\_

Employee: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Company: \_\_\_\_\_

Deduction Code: \_\_\_\_\_ Group Number \_\_\_\_\_

Pay Period Ending: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Additional Pay Periods: \_\_\_\_\_

Total Refund: \$\_\_\_\_\_

Check Payable to: \_\_\_\_\_

Mail To: KRISTEN MITCHELL  
DEPARTMENT OF CHILDREN AND FAMILIES  
HUMAN RESOURCES, HEADQUARTERS  
1317 WINEWOOD BOULEVARD  
BUILDING 1, ROOM 133A  
TALLAHASSEE, FLORIDA 32399-0700  
Phone: (850) 921-2724, Email: [employee\\_benefits@dcf.state.fl.us](mailto:employee_benefits@dcf.state.fl.us)

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Comments: