

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) 717-4559, Email: employee_benefits@dcf.state.fl.us

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Comments:

