

REQUEST FOR REFUND  
FLORIDA DEPARTMENT OF HEALTH  
Human Resources, Headquarters

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

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

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

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

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

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

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

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

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

Mail To: Emily Reker  
Department of Health  
Human Resources, Headquarters  
4052 Bald Cypress Way, BIN BO3  
Tallahassee, FLORIDA 32399-1731  
Phone: (850) 245-4184, Email: [Emily.Reker@flhealth.gov](mailto:Emily.Reker@flhealth.gov)

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Comments: