NYS OFFICE OF THE STATE COMPTROLLER
BUREAU OF PAYROLL SERVICES
REQUEST FOR SOCIAL SECURITY/MEDICARE TAX REFUND

AGENCY CODE: _____ TAX YEAR: _____ AMOUNT: 0.00

EMPLOYEE ID: _____ EMPLOYEE NAME: _____

NOTE: Please fill out one form per tax year for each employee.

CHECK DATE	FICA WAGES	SS TAX	MED TAX
TOTAL	0.00	0.00	0.00

(11/15)