

SIGNATURE OF CARE PROVIDER _

Mobile Upload Electronic Claim submission:

https://secure.ebpabenefits.com

Fax: 603-773-4415

Mail To: EBPA Reimbursement Accounts

P.O. Box 1140 Exeter, NH 03833-1140

Phone: 888-678-3457

DEPENDENT CARE ACCOUNT REIMBURSEMENT REQUEST FORM

ADDRESS (STREET) EMPLOYER ADDRESS (CITY, STATE, ZIP CODE) LOCATION/DIVISION You must have an itemized bill (or have the provider sign this form) and the taxpayer ID Number from each person providing List each dependent receiving care on a separate line. List each provider on a separate line. Attach the appropriate documentation information. DEPENDENTS FULL NAME AGE RELATIONSHIP DATES OF CARE: FROM: TO DATES OF CARE: FROM: TO PEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER: FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER: FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER: TOTAL 1. Locrify that the above listed expense(s) have been incurred by me or my eligible dependent(s) (as defined by the IRS). 2. Locrify that all applicable insurance or other health benefits have been exhausted. 3. Locrify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements. 4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions. ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE							
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SIGNATURE DATE:	SIGNATURE					DATE:	

(Required only if no itemized receipt is attached)

__ DATE:_