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

NAME	SOCIAL SECURITY NUMBER (optional)
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 care.
- List each dependent receiving care on a separate line. List each provider on a separate line.
- Attach the appropriate documentation information.

DEPENDENT'S FULL NAME	AGE	RELATIONSHIP	DATES OF CARE: FROM:	TO	NAME OF PROVIDER OF CARE	AMOUNT (ATTACH PROOF OF EXPENSE INCURRED)
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL 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. I certify that the above listed expense(s) have been incurred by me or my eligible dependent(s) (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify 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.
5. I have received the taxpayer ID # of my care provider.

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE

SIGNATURE _____ DATE:_____

SIGNATURE OF CARE PROVIDER _____ DATE:_____

(Required only if no itemized receipt is attached)