MAIL TO: EBPA
REIMBURSEMENT ACCOUNT
P.O. BOX 5080
HAMPTON, NH 03842

REIMBURSEMENT REQUESTS MAILED TO THE INCORRECT ADDRESS WILL DELAY YOUR CLAIM.

REIMBURSEMENT REQUEST FORM
MINIMUM REIMBURSEMENT FROM EACH ACCOUNT IS $25.00

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET)	EMPLOYER
ADDRESS (CITY, STATE, ZIP CODE)	LOCATION/DIVISION

MEDICAL/DENTAL CARE ACCOUNT

-List each reimbursable expense separately. you must have itemized bills for each expense.
-Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing) or O (Other) Type of Expense.
-If an expense is covered in part by a health plan, the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A coy of the health plan's payment voucher or denial MUST be submitted with the claim. If no health plan applies write "none" in the Plan Payment column.
-Attach a second form if you need additional space.

TYPE OF EXPENSE	EXPSENSES FOR			DATES OF SERVICE		TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE
	FIRST NAME	AGE	RELATIONSHIP	FROM	TO			
						.	.	.
						.	.	.
						.	.	.
						.	.	.
						.	.	.
				TOTALS				. ($25.00 MINIMUM)

DEPENDENT CARE ACCOUNT

-You must have an itemized bill 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.

DEPENDENTS FULL NAME	AGE	RELATIONSHIP	DATES OF CARE		NAME OF PROVIDER OF CARE	AMOUNT (ATTACH PROOF OF EXPENSE INCURRED)
			FROM	TO		
FEDERAL TAXPAYER ID# OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID# OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID# OR SOCIAL SECURITY # OF PROVIDER:						
					TOTALS	($25.00 MINIMUM &

1. I certify that the aove listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other medical insurance 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.

SIGNATURE: _____ DATE: _____

ALLDISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE.

USNHFSAPM3.3/90