

FLEXBenefits Request for Reimbursement

Mail or fax completed claim form and documentation to:
EBS
 214 N Main St, PO Box 1053
 Burlington, IA 52601
 Fax: (319)758-6271
 flex@ebs-tpa.com



DO NOT USE A FAX COVER SHEET

Date: _____

of pages: _____

- Original Submission Re-submission
 Letter of medical necessity on file

Employee Information-Complete all sections

Name:			Social Security Number:		
Home Address:			Employer:		
City:	State:	Zip:	Daytime phone:		
<input type="checkbox"/> Check here if this is a new address		Email Address:			

Flexible Spending Account Reimbursement-Attach an itemized receipt, an Explanation of Benefits, or other verification (originals or photocopies) of each expense claimed, indicating the service(s) provided, date(s) of service, and corresponding charges. **Credit card receipts, cancelled checks, balance forward statements are not eligible forms of documentation.**

Person Receiving Care	Relationship	Date of Service	Description of Expense	Care Provider (Name of Doctor, Clinic, Hospital)	Amount Claimed

Dependent Care Reimbursement-Attach an itemized receipt or other verification of each expense claimed, indication the service(s) provided, date(s) of service, and corresponding charges. This documentation is not needed if care provider's certification is obtained below.

Dependent Receiving Care	Relationship	Age	Dates of Care	Care Provider (Name and SSN or T.I.N.)	Amount Claimed

I Certify that the dependent care expenses shown above are valid.

Signature of Dependent Care Provider: _____ **Date:** _____

Employee Certification: I request reimbursement from the Employee Reimbursement Account for the expense itemized above. These expenses were incurred within the current plan year, unless otherwise indicated. I certify that these expenses are not eligible for reimbursement from any other sources. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and as outlined on the reverse side of this form. I also understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. The information on this Request for Reimbursement is true and correct to the best of my knowledge.

Employee Signature: (REQUIRED) _____ **Date:** _____