eba&m CORPORATION
3505 Cadillac Ave., #0-201
Costa Mesa, CA 92626
Attn: Flex Department
Fax: 714-437-1142

SECTION 125 FLEXIBLE SPENDING

REIMBURSEMENT REQUEST FORM

EMPLOYER NAME	BRANCH LOCATION	GROUP NUMBER
EMPLOYEE'S LAST NAME	FIRST M.I.	BIRTHDATE / / ☐ MALE ☐ FEMALE
ADDRESS STREET		SOCIAL SECURITY NUMBER

☐ CHECK HERE IF NEW

CITY	STATE	ZIP	IF NAME CHANGE, GIVE FORMER NAME

I. Health Flexible Spending Account

EBA&M USE ONLY

Other Medical Expenses	**Amounts Paid**
1. Medical Expenses	$
2. Dental Expenses	
3. Vision Expenses	
4. Prescription Copays	
5. Over-the-counter Expenses	
TOTAL AMOUNT REQUESTED	$

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO VALIDATE ALL REIMBURSEMENT SUBMISSIONS. DOCUMENTATION MUST BE A COPY OF THE BILLING, A RECEIPT WHICH INDICATES THE PERFORMANCE AND PAYMENT OF THIS SERVICE, OR A COPY OF AN EXPLANATION OF BENEFITS (EOB) FORM FROM YOUR HEALTH CARRIER. ACCOUNT BALANCE STATEMENTS CAN NOT BE ACCEPTED. YOU MUST SUBMIT AN ITEMIZED RECEIPT OR EOB.

II. Dependent Care Flexible Spending Account

Dependent Name(s)	**Relationship**	**Age**

DEPENDENT INFORMATION MUST BE COMPLETED FOR REIMBURSEMENT TO BE PROCESSED.

Daycare Provider Name _____

Address _____

City _____ State _____ Zip _____

Tax I.D. or Social Security # _____

Day Care Provider's Signature **Date**

Dates of Care	**Amounts Paid**
	$

I hereby certify that the information reported in this voucher is correct and that I have not previously received reimbursement for these charges from this or any other plan of coverage. I understand that these expenses may not be claimed for credit or deduction on my personal income tax return.

Participant's Signature **Date**