EBA&M
EMPLOYEE BENEFITS
ADMINISTRATION & MANAGEMENT

18002 Cowan Irvine, CA 92614
Fax: (714) 437-1142 Attn: Flex Department

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**
1. Deductibles / Coinsurance	$ _____
2. Unreimbursed Medical Expenses	$ _____
3. Unreimbursed Dental Expenses	$ _____
4. Unreimbursed Vision Expenses	$ _____
5. Other _____	$ _____
TOTAL AMOUNT REQUESTED	**$ _____**

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

II. Dependent Care Flexible 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 # _____

Daycare Provider's Signature **Date**

Dates of Care	**Amounts Paid**
	$
	$
	$
	$

I hereby certify that the information 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.

Signature _____ Date _____