EBMC

EMPLOYEE BENEFIT MANAGEMENT CORP

Return to:

EMPLOYEE BENEFIT MANAGEMENT CORP
Attention: Flexible Spending Department
4789 Rings Road
Dublin, Ohio 43017-1599
Phone: (614) 766-5800 Fax: (614) 766-0901

FLEXIBLE SPENDING
REQUEST FOR REIMBURSEMENT FORM

EMPLOYEE NAME: _____ **SS#:** _____
LAST FIRST MI

If address has changed, please complete:

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

EMPLOYER: _____ **DAYTIME PHONE#:** _____

HEALTH CARE REIMBURSEMENT ACCOUNT

Please indicate below the amount of reimbursement you are requesting. Receipts must be attached.

MEDICAL $ _____ VISION $ _____

DENTAL $ _____ OTHER $ _____

TOTAL HEALTH CARE EXPENSE $ _____ FROM: _____ TO: _____
[DATES INCURRED]

DEPENDENT CARE REIMBURSEMENT ACCOUNT
(Day Care Expense)

Please indicate below the amount of reimbursement you are requesting. Receipts must be attached.

NAME OF DEPENDENT(s) _____

AMOUNT OF EXPENSE $_____ FROM:_____ TO:_____
[DATES INCURRED]

Under IRS Rules, you are required to report the name, address and taxpayer identification number of each day care provider on your federal income tax return.

I hereby request reimbursement for the above-noted expenses.
I certify that my request to be reimbursed complies with the Flexible Spending Program and Internal Revenue Code requirements. I further certify that the expenses outlined above have not been reimbursed, are not reimbursable under any other Plan, and that the dependent care expenses (if applicable) qualify as an eligible expense under the terms of the Plan. Furthermore, I understand that expenses reimbursed under this Plan cannot be deducted or taken as a tax credit on my income taxes. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

_____ _____
Signature of Employee **Date**