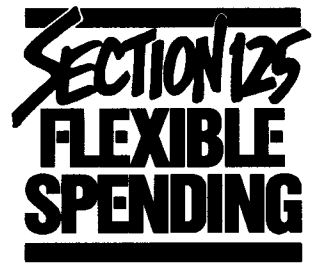




3505 Cadillac Ave., #0-201
 Costa Mesa, CA 92626
 Attn: Flex Department
 Fax: 714-437-1142



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

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 \$ _____**

| EBA&M USE ONLY |
|----------------|
| |

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 | 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 _____