



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
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## 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	_____
<b>TOTAL AMOUNT REQUESTED</b>	<b>\$ _____</b>

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 \_\_\_\_\_