Electronic Claim submission:
https://secure.ebpabenefits.com
Fax: 603-773-4415
Mail To: EBPA Reimbursement Accounts
P.O. Box 1140
Exeter, NH 03833-1140
Telephone: 888-678-3457

LIMITED PURPOSE FSA REIMBURSEMENT REQUEST FORM

NAME	SOCIAL SECURITY NUMBER (optional)
ADDRESS (STREET)	EMPLOYER
ADDRESS (CITY, STATE, ZIP CODE)	LOCATION/DIVISION

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision).
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.

TYPE OF EXPENSE	EXPENSE FOR: FIRST NAME		RELATIONSHIP	DATES OF SERVICE: FROM	TO	TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE
				TOTALS				

1. I certify that the above listed expense(s) have been incurred by me or my eligible dependent(s) (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.

SIGNATURE _____ DATE: _____