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: | | | DATES OF SERVICE: | | TOTAL BILL (ATTACH COPY) | PLAN PAYMENT (ATTACH PAYMENT OR DENIAL) | AMOUNT OF REIMBURSEMENT DUE |
|---|---|---|---|---|---|---|---|---|
| | FIRST NAME | | RELATIONSHIP | FROM | TO | | | |
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| | | | | | **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:__________________