



Employee Benefit Management Services, Inc.

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Request for Flex Reimbursement

Form with fields: Employer Name, Employer Group Number, Employees Last Name, First Name, Employee's ID Number, Address, E-mail Address

Health Care Expenses

Table with 5 columns: Date of Service, Provider, Description of expense, Patient Name, Amount Requested. Includes a Total amount requested row.

Dependent Care Expenses

Table with 5 columns: Name of dependent, Date of birth, Daycare Provider Name & Tax ID number, Dates of Service, Amount Requested. Includes a Total amount requested row.

Participants must submit a copy of the receipt or bill for dependent care service detailing the name, address and tax ID/SSN of the provider as well as dates of service being claimed.

Note: The tax identification number or Social Security number of the provider is required on all submissions.

Daycare provider's Signature: _____ Date: _____

To the best of my knowledge and belief, my statements in the Request for Flex Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants.

Employee Signature: _____ Date: _____