



Employee Benefit Management Services, Inc.

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REQUEST FOR REIMBURSEMENT

Please complete applicable spaces on this form, attach appropriate Bills/Receipts, and forward to EBMS. (Cancelled checks or balance due statements are not acceptable bills.)

Employer _____ Group Number _____

Employee Name _____ Member ID # _____
Last First Middle

Home Address _____
Number/Street City State Zip

UNREIMBURSED MEDICAL EXPENSE CLAIMS/HEALTH FLEX

Table with 5 columns: Date Incurred, Name of Service Provider, Expense Description, Person for Whom Incurred, Net Amount. Includes a row for TOTAL MEDICAL CARE EXPENSE CLAIM.

DEPENDENT CARE EXPENSE CLAIMS

Table with 4 columns: Name of Dependent(s), Period Covered (From, To), Name, Address and Taxpayer Identification Number of Provider of Service, Amount Incurred. Includes a row for TOTAL DEPENDENT CARE EXPENSE CLAIM.

MASS TRANSIT/PARKING EXPENSE CLAIMS

Table with 4 columns: Type of Reimbursement (Transit, Parking, Vanpool), Period Covered (From, To), Amount Incurred. Includes a row for TOTAL COMMUTE EXPENSE CLAIM.

To the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred during the applicable plan year by eligible plan participants. If Medical Claim - The medical expense requested has not been reimbursed or is not reimbursable by any other health coverage and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested. If Mass Commuting/Parking claim- I certify that I have incurred these services and that they are reimbursable under the terms of my employer's Commute Reimbursement Program. I understand that I am solely responsible for the validity of the claims submitted. These services have not been reimbursed prior to this submission and are not reimbursable by any other source.

Employee's Signature _____ Date _____

For Dependent Care Expenses, the following must be completed by the Daycare Provider if ne receipt is available: To the best of my knowledge, I certify that the information above regarding dependent care expenses is complete and true.

Dependent Care Provider Signature (If no receipt is available) _____ Date _____