###3T00011####################

Electronic Claim submission:
EBPA_Receipts@alegeus.com
Fax: 321-445-9607
Mail To: EBPA Reimbursement Accounts
P.O. Box 1140
Exeter, NH 03833-1140
Telephone: 888-678-3457

FSA ACCOUNT
REIMBURSEMENT CLAIM 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), H (Hearing), or O (Other), under Type of Expense.
- 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.
- Attach a second form if you need additional space.

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.

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE

ELECTRONIC SIGNATURE _____ DATE: _____