Dependent Care Reimbursement Account
Health Care Expense Reimbursement Account
Request for Reimbursement

Ohlone Community College District

Fill out form, sign, and mail. Instructions on back.

GRA-22400-6	Employee name	Social Security number __ __ __ - __ __ - __ __ __ __
Employee's home address (number/street, city, state, zip)		☐ Check is this is a new address

Expenses incurred for:

Name ____________________	Name ____________________	Name ____________________
1. Relationship to employee *(Check One)* ☐ Self ☐ Spouse ☐ Dependent	**1. Relationship to employee** *(Check One)* ☐ Self ☐ Spouse ☐ Dependent	**1. Relationship to employee** *(Check One)* ☐ Self ☐ Spouse ☐ Dependent
2. Type of service *(Check One)* ☐ Dependent care ☐ Health care *(please specify)* ☐ Medical ☐ Dental ☐ Vision	**2. Type of service** *(Check One)* ☐ Dependent care ☐ Health care *(please specify)* ☐ Medical ☐ Dental ☐ Vision	**2. Type of service** *(Check One)* ☐ Dependent care ☐ Health care *(please specify)* ☐ Medical ☐ Dental ☐ Vision
3. Provider of service (Doctors, Hospital, Pharmacy, Dependent Care Provider, etc.) ________________ Name ________________ City State	**3. Provider of service** (Doctors, Hospital, Pharmacy, Dependent Care Provider, etc.) ________________ Name ________________ City State	**3. Provider of service** (Doctors, Hospital, Pharmacy, Dependent Care Provider, etc.) ________________ Name ________________ City State
4. Date(s) of service From ________ Through ________	**4. Date(s) of service** From ________ Through ________	**4. Date(s) of service** From ________ Through ________
5. Amount to be reimbursed* $________________	**5. Amount to be reimbursed*** $________________	**5. Amount to be reimbursed*** $________________
6. Proof of expense** *(Check one)* Attach copy of: ☐ Itemized bill showing service dates or ☐ Explanation of benefits from medical administrator or ☐ Statement from dependent care provider or ☐ Other proof of claim *(Explain)* ____________________	**6. Proof of expense**** *(Check one)* Attach copy of: ☐ Itemized bill showing service dates or ☐ Explanation of benefits from medical administrator or ☐ Statement from dependent care provider or ☐ Other proof of claim *(Explain)* ____________________	**6. Proof of expense**** *(Check one)* Attach copy of: ☐ Itemized bill showing service dates or ☐ Explanation of benefits from medical administrator or ☐ Statement from dependent care provider or ☐ Other proof of claim *(Explain)* ____________________

* *The amount to be reimbursed must be filled in. If an amount is not indicated, no payment will be made.*

** *Always retain copies of any proof of expense submitted with this Request for Reimbursement*

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred by the named person(s). I certify that these expenses have been and will not be reimbursed under any other employer sponsored benefit plan and will not be claimed as an income tax deduction. Also, I certify that these expenses have not been previously reimbursed under this plan.

I authorize that my Plan Account may be reduced by the amount of the reimbursement.

Employee's signature	Date

Return your Request for Reimbursement and proof of expense to:

EBS
P.O. Box 11657
Pleasanton, CA 94588-1657

1-800-229-7683

Instructions for Submitting Requests
For Reimbursement

- You can submit requests for reimbursement for eligible medical, dental and vision care expenses that will not be reimbursed by any other employer sponsored benefit plan and which would qualify as a deduction on your income tax return.

- You can submit requests for reimbursements for eligible dependent care expenses that will not be reimbursed by any other employer sponsored benefit plan and which would qualify as a credit on your income tax return.

- Expenses must be incurred during the Plan year. (Plan year is January 1 through December 31.)

To Submit a Request for Reimbursement

- Complete all applicable items on the reverse side. Please be certain to fill in the amount to be reimbursed. If an amount is not included, no payment will be made.

- Submit with this form, proof of your expenses – either an **Itemized Bill** from your medical provider (reflecting patient's name, date of service, type of service, type of treatment, expense incurred, prescription number), an **Explanation of Benefits** from your insurer, or a **Statement of Service** from your dependent care provider (reflecting date of service, amount charged and provider's signature).

- Requests for reimbursements can be made at any time as long as the accumulated expenses equal or exceed $100.

    a. Requests for reimbursement can be made up to three months beyond the end of the Plan year. That is, you may submit requests through the month of December for expenses you incurred during the previous Plan year.
    b. Requests for reimbursement for expenses totaling less than $100 may be submitted during the last month of the Plan year or during the run-off period.

- Reimbursements are not assignable and can only be payable to you, not to the provider.

- Return your Requests for Reimbursement and proof of expense to:

    EBS
    P.O. Box 11657
    Pleasanton, CA 94588-1657

If you have any questions regarding your reimbursements, please contact the Reimbursement Account Department by phoning **1-800-229-7683.**