THE UNIVERSITY OF VERMONT

CBA ebpa

UPLOAD SCANNED DOCUMENTS VIA EPBA REIMBURSEMENT PORTAL OR

MAIL OR FAX TO: REIMBURSEMENT ACCOUNT
P.O. BOX 1140
EXETER, NH 03833-1140
PHONE: 888-678-3457
FAX: 603-773-4415

REIMBURSEMENT REQUEST FORM

DEPENDENT CARE ACCOUNT

- You must have an itemized bill (or have the provider sign this form) and the taxpayer ID Number from each person providing care.
- List each dependent receiving care on a separate line.
- List each provider on a separate line.
- Attach the appropriate documentation information.

NAME	Employee ID NUMBER 99-
ADDRESS (STREET)	EMPLOYER **UNIVERSITY OF VERMONT**
ADDRESS (CITY, STATE, ZIP CODE)	

DEPENDENTS FULL NAME	AGE	RELATIONSHIP	DATES OF CARE: FROM TO	NAME OF CARE PROVIDER	AMOUNT (ATTACH PROOF OF EXPENSE)
FEDERAL TAXPAYER ID# OR SOCIAL SECURITY# OF PROVIDER					
DEPENDENTS FULL NAME	AGE	RELATIONSHIP	DATES OF CARE: FROM TO	NAME OF CARE PROVIDER	AMOUNT (ATTACH PROOF OF EXPENSE)
FEDERAL TAXPAYER ID# OR SOCIAL SECURITY# OF PROVIDER					
DEPENDENTS FULL NAME	AGE	RELATIONSHIP	DATES OF CARE: FROM TO	NAME OF CARE PROVIDER	AMOUNT (ATTACH PROOF OF EXPENSE)
FEDERAL TAXPAYER ID# OR SOCIAL SECURITY# OF PROVIDER					
			TOTAL		

1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
3. I will assume all responsibility for taxes or penalties arising our of any disallowed deductions.
4. I have received the taxpayer ID Number of my care provider.

SIGNATURE_____ DATE:_____

SIGNATURE OF CARE PROVIDER:_____ DATE:_____

ALL CLAIMS FAXED/RECEIVED BY 12 NOON ON MONDAY WILL BE PROCESSED AND DISBURSED BY THE FOLLOWING MONDAY