The Difference Card

EB EMPLOYEE SOLUTIONS, LLC

*This form may be used for all Flexible Spending Account Reimbursement Requests (FSA, DCA)

FSA REIMBURSEMENT FORM

NUMBER OF PAGES FAXED:	PHONE NUMBER FOR QUESTIONS:

TO BE COMPLETED BY EMPLOYEE:

COMPANY NAME	
EMPLOYEE NAME (First, Middle, Last)	
EMPLOYEE ADDRESS	
EMPLOYEE SOCIAL SECURITY NUMBER	EMAIL ADDRESS

To the best of my knowledge and belief, my statements in the request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year for myself and/or my legal dependents. I certify that these expenses have not been previously reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached reciepts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

EMPLOYEE SIGNATURE FOR VERIFICATION *(Required for processing submission)* _____ DATE (MM/DD/YYYY) _____

STEP 1: Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Healthcare expenses must be processed by your insurance company first. The insurance company will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service provided, not when you are billed or pay for the service.

COMPLETE THIS SECTION IF YOU PROVIDE RECEIPTS:

Reimbursement Reminders	DATE OF SERVICE	PROVIDER	NAME OF PATIENT (FSA ONLY)	TYPE OF SERVICE	AMOUNT
1. You must complete the boxes in this section for each expense in order for your claim to be processed properly.					$
2. Your receipts must contain the following: Date of Service, Provider, Type of Service, Amount of Service & Social Security Number or Tax ID Number.					$
					$
3. Expenses must be totaled on each page.					$
4. Copies of receipts for each expense claimed must be attached to the form.					$

COMPLETE THIS SECTION IF YOU <u>DO NOT</u> PROVIDE RECEIPTS (FOR DEPENDENT CARE ONLY):

Reimbursement Reminders	SIGNATURE OF DEPENDENT CARE PROVIDER (Required if receipts are not provided)		
1. You must complete the boxes in this section for each expense in order for your claim to be processed properly.	DEPENDENT CARE PROVIDER'S NAME:		
2. This completed reimbursement form serves as your receipt.	DATE OF SERVICE:	SOCIAL SECURITY OR TAX ID# :	$
		TOTAL DEPENDENT CARE EXPENSE:	$

STEP 2: Return this completed reimbursement form and appropriate documentation. Please keep original receipts for your records as requested by the IRS.

Please complete this form and submit it by the following methods: (If you have questions, call **Customer Care** at **888-343-2110**

Mail it to: **The Difference Card, PO Box 322 Mount Kisco, NY 10549**, OR
Fax it to: **(602)333 4252**