P.O. Box 928
Findlay, OH 45839
651-695-2500
800-486-7664
Fax: 419-423-5834
www.ebsobenefits.com

DEPENDENT CARE REIMBURSEMENT CLAIM FORM
(Priority Processing)

To Be Completed By Provider

I ___________________________ (provider) hereby certify that I have provided dependent care service to ____________________________ (employee) for the care of his/her child(ren) for the period of

_______________20 ______ to _______________ 20 ______. The amount charged was $______________.

Provider's Signature____

- or -

___ Attached are bills, receipts and/or statements for proof of daycare.
Canceled checks are unacceptable.

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To Be Completed By Employee

Send check in the amount of $__________________

Checks cannot be issued for amounts that are greater than the current account balance, exceed the actual charges for services, or for services not yet provided. If a request is submitted for amounts greater than the account balance, the outstanding amount will be pended, and will then be paid when the account balance is again greater than the amount pended.

Please Print
Employee Name____

ID#_____________________ Primary E-mail Address __________________________________

Employer Name____

Employee Signature_______________________________________ Date____________________

NOTE: All reimbursements will be paid to the employee

Please send completed and signed copy to customerservice@ebsobenefits.com or to the fax number or mailing address at the top of this form. Questions, contact EBSO, Inc. Customer Service at 651-695-2500 or 800-486-7664.

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