

EMPLOYEE DEPENDENT CARE
REIMBURSEMENT VOUCHER
CAFETERIA PLAN

Mail directly to:
EBCA, Inc.
PMB 350
2200 Winter Springs Blvd Suite 106
Oviedo, FL 32765-9344

EMPLOYEE NAME (Print Clearly): _____ SSAN: _____

EMPLOYER: _____ DATE: _____

DATE OF EXPENSE: ____ / ____ / ____ AMOUNT CLAIMED: \$ _____

NAME AND AGE OF CHILD(REN): _____

NAME AND ADDRESS OF SERVICE PROVIDER: _____

SOCIAL SECURITY NUMBER OR TAX IDENTIFICATION NUMBER OF SERVICE PROVIDER: _____

IMPORTANT: You must attach a copy of evidence from a third party showing the date of service and expense you have incurred. Do not submit a cancelled check. The expense must be incurred during the current Cafeteria Plan year.

I hereby certify this is a valid expense under Section 125 of the Internal Revenue Code. I certify my dependent is under 13 years of age and I claim the dependent on my taxes as a dependent, or the dependent or spouse is incapable of caring for himself or herself and I claim as a dependent on my taxes. I do not claim this service provider as a dependent. This expense is for the purpose of enabling me to work. This expense has actually been incurred by me and has not been reimbursed in any way, nor will I claim this amount as a Tax Credit.

For Administrative Use Only
Approved Amt: _____ Plan Year: _____
Description: _____
Admin. Codes: ____ / ____

Employee Signature: _____