

**EMPLOYEE FLEXIBLE SPENDING ACCOUNT  
CAFETERIA PLAN  
REIMBURSEMENT VOUCHER**

Mail Directly To:  
EBCA, Inc.  
PMB 350  
2200 Winter Springs Blvd Suite 106  
Oviedo, Florida 32765-9344

EMPLOYEE NAME (Print Clearly): \_\_\_\_\_ SSN: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF EXPENSE: \_\_\_/\_\_\_/\_\_\_ AMOUNT CLAIMED: \$ \_\_\_\_\_

**DETAILS OF MEDICAL EXPENSE:**

Claim on: SELF: \_\_\_ DEPENDENT: \_\_\_ Dependent Name: \_\_\_\_\_

Relationship of Dependent to Employee: \_\_\_\_\_

Brief Explanation of Medical Expense: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT:** You must attach a copy of evidence from a third party showing the date of service and expense you have incurred.

I hereby certify that this is a valid expense under Section 125 of the Internal Revenue Code. I have actually incurred this expense, and I have not been nor will I be reimbursed by insurance of any other method for this expense. I understand that money received from this claim is not reportable income, and that this expense will not be eligible for any other tax deduction or credit.

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

Employee Signature: \_\_\_\_\_

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