



MAIL TO: EBPA REIMBURSEMENT ACCOUNTS  
 P.O. BOX 1140  
 EXETER, NH 03833-1140  
 Fax: 603-773-4415  
 Electronic Claim submission:  
<https://secure.ebpabenefits.com>  
 Telephone: 888-678-3457

### REIMBURSEMENT REQUEST FORM

NAME	SOCIAL SECURITY NUMBER (OPTIONAL)
ADDRESS (STREET)	EMPLOYER: <b>University of Maine System</b>
ADDRESS (CITY, STATE, ZIP CODE)	LOCATION/DIVISION

#### HEALTH CARE ACCOUNT

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other), under Type of Expense.
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.
- Attach a second form if you need additional space.

TYPE OF EXPENSE	EXPENSE FOR:		DATES OF SERVICE:		TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE
	FIRST NAME	RELATIONSHIP	FROM	TO			
<b>TOTALS</b>							

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE.

**You have until 12/31 to incur the expenses and until 4/15 to submit the claims**