THE NEW SCHOOL

MAIL or FAX TO: EBPA REIMBURSEMENT ACCOUNTS
P.O. BOX 1140
EXETER, NH 03833-1140
Phone: 888-678-3457
Fax: 603-773-4415

DEPENDENT CARE REIMBURSEMENT REQUEST FORM

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET)	EMPLOYER **THE NEW SCHOOL**
ADDRESS (CITY, STATE, ZIP CODE)	

- You must have an itemized bill (or have the provider sign this form) and the taxpayer ID Number from each person providing care.
- List each dependent receiving care on a separate line. List each provider on a separate line.
- Attach the appropriate documentation information.

DEPENDENT'S FULL NAME	AGE	RELATIONSHIP	DATES OF CARE: FROM:	TO	NAME OF PROVIDER OF CARE	AMOUNT (ATTACH PROOF OF EXPENSE INCURRED)
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
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FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
					TOTAL	

1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.
5. I have received the taxpayer ID # of my care provider.

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

SIGNATURE _____ DATE:_____

SIGNATURE OF CARE PROVIDER _____ DATE:_____

ebpa