EBS-RMSCO, Inc.
Employee Benefit Solutions

Dependent Care Account (DCAP) Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

To Be Completed by the Dependent Care Provider

Provider Information

Name: _____

Address: _____

City, ST, Zip: _____

Tax Payer ID/ SSN: _____

Dependent Care For:

Name: _____ Age: _____

Dates of Care:

Dates: __ __/__ __/__ __ __ __ to __ __/__ __/__ __ __ __

Start Date End Date

Amount Charged:

Amount: $_____

Provider Signature:

Signed: _____

Participant Authorization

- I authorize the above expenses to be reimbursed from my dependent care account.
- I certify that the expenses qualify as valid dependent care expenses under the terms of the Plan and that the family member receiving the services is a qualifying individual as defined in the Plan.
- I certify that these expenses have not previously been reimbursed and I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit.
- I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification number.
- Mail to EBS-RMSCO, Inc., FSA Dept, PO Box 2330, Blasdell, NY 14219; Fax (877) 256-7228.
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS-RMSCO, Inc., I certify that the information here is true and correct.