Emergency Care Affidavit/Employee Reimbursement Form

Employee's name (please print) **Home address (street, city, state, zip)** **Employee's email address**	**Villanova University** **Faculty** ____ **Staff** ____

Employee's social security number	**Employee's daytime telephone number**
Emergency care provider's name	**Provider's telephone number**
Emergency care provider's relationship to employee **friend or family member** ____ **professional care provider** ____	**Care took place** **in employee's home** _____ **at provider's site** _____

Names of dependent(s) who received care	**Date(s) of birth**
Reason for care	
Please indicate dates and hours when you used emergency care *NOTE: Claim form must be received within 60 days of using care for reimbursement.*	**Cost of care per day**

Emergency Care Provider's Affidavit

I, the undersigned, provided care for the dependent named above for the date, hours, fees, and circumstances listed above.

_____ _____
Name Date

Employee's Affidavit

I, the undersigned, hired the above provider to supply emergency care for my dependent, in accordance with the date, hours, fees, and circumstances listed above. I understand that falsifying the information or circumstances described here is a serious offense and may be grounds for disciplinary action by my employer. I also understand that neither Health Advocate nor my employer are legally liable for the provided care. By signing my name and submitting this form for reimbursement, I affirm the information above to be true and agree to the conditions and limitations of the Villanova University Backup Care Reimbursement program.

_____ _____
Name Date

The Villanova University Back-Up Reimbursement Program

Please complete all information and return this form to Health Advocate, worklife@healthadvocate.com. You may also fax to 610-644-1134. Be sure to make a copy for your records.