Emergency Care Affidavit/Employee Reimbursement Form

<table>
<tr><td colspan="2">Employee's name (please print)

Home address (street, city, state, zip)

Employee's email address</td><td colspan="2">Villanova University

Faculty ____
Staff ____</td></tr>
<tr><td colspan="2">Employee's social security number</td><td colspan="2">Employee's daytime telephone number</td></tr>
<tr><td colspan="2">Emergency care provider's name</td><td colspan="2">Provider's telephone number</td></tr>
<tr><td colspan="2">Emergency care provider's relationship to employee
friend or family member ____
professional care provider ____</td><td colspan="2">Care took place
in employee's home _____
at provider's site _____</td></tr>
<tr><td colspan="3">Names of dependent(s) who received care</td><td>Date(s) of birth</td></tr>
<tr><td colspan="4">Reason for care</td></tr>
<tr><td colspan="3">Please indicate dates and hours when you used emergency care

NOTE: Claim form must be received within 60 days of using care for reimbursement.</td><td>Cost of care per day</td></tr>
<tr><td colspan="4">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 ____________________</td></tr>
<tr><td colspan="4">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 ____________________</td></tr>
</table>

The Villanova University Back-Up Reimbursement Program

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