Employee Benefits Corporation

Claim Form

Phone support: **(800) 346-2126** | (608) 831-8445
Email: **participantservices@ebcflex.com**

How to complete the Claim Form

1. Complete the **Account Holder Information** section in full.

   Be sure to include the last 4 digits of your Social Security or Identification Number and your email address.

2. Review the **Benefit Codes**.

   A. Enter the Benefit Code for your claim:

   [F] Health Care FSA (BESTflex Plan FSA that reimburses medical, dental and vision expenses)

   [L] Limited Health Care FSA (BESTflex Plan FSA that reimburses dental and vision expenses)

   [D] Dependent Care FSA (BESTflex Plan FSA that reimburses daycare expenses)

   [I] Individual Billed Insurance Premiums (BESTflex Plan account that reimburses insurance premiums)

   [H HRA (EBC HRA reimbursement)

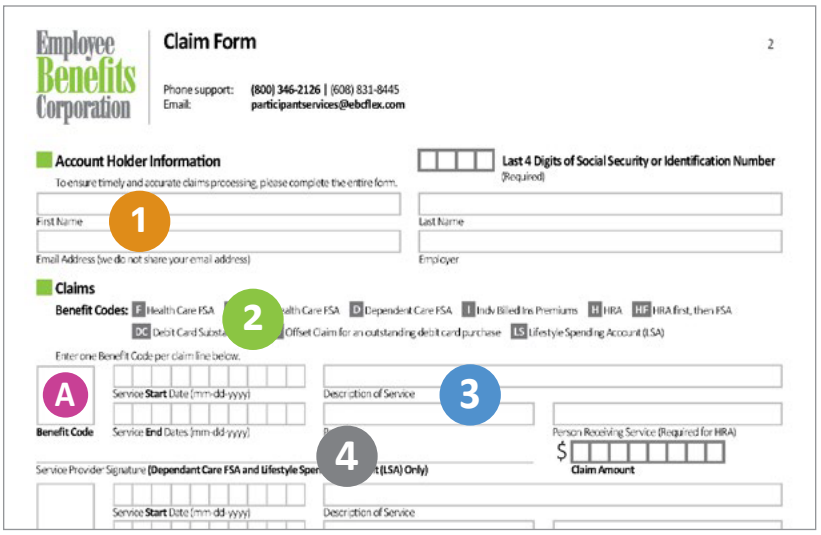
   [HF] Product Linking (Allows expense to be reimbursed out of the EBC HRA first, then the BESTflex Plan Health Care FSA/Limited Health Care FSA. If your EBC HRA allows rollover, this feature is not available. If the expense is not eligible in one of your plans, the whole amount will be processed from the eligible plan.

   [DC] Debit Card Substantiation

   [O] Offset Claim for an outstanding debit card purchase

   [LS] Lifestyle Spending Account (LSA)

   Be sure to include a "Benefit Code" for each claim; your claim cannot be processed without it.



3. Complete the **Claims Section**.

   Information **required** in order to process the claim:

   - Date of Service - both start and end date
   - Dollar amount for each line
   - Name of provider
   - Description of Service
   - Total dollar amount for the entire page

4. If applicable, obtain the **Service Provider Signature** for Dependent Care and Lifestyle Spending Account (LSA) expenses.

Important information you need when submitting claims to Employee Benefits Corporation

- If we have your email address on file, we will email you when your claim is processed. Please allow 2 business days from our receipt of your *Claim Form* before viewing the status of your online account in My Account Assistant (log in at www.ebcflex.com).
- Remember to send appropriate claim documentation with your form that substantiates the expenses you are submitting for reimbursement. Claim documentation must include the Provider Name, the Date(s) of Service, a Description of the Expenses incurred and the Expense Amount. Cancelled checks and non-itemized credit card receipts are not valid forms of documentation.
- Retain original copies of the *Claim Form* and expense documentation for your files; Claim Forms, receipts and claims information will not be returned.
- If you request that we reissue a claim reimbursement to you for any reason, there is a $25 stop payment fee.

Lifestyle Spending Account Expenses

- Refer to the *Plan Overview Document* to review your plan's eligible expenses. Medical expenses are not eligible.
- For Lifestyle Spending Account (LSA) expenses a service provider signature is required when an itemized receipt is not available for the service rendered.
- Refer to the *Plan Overview Document* for the length of your runout period, which determines the number of days you have after the plan year ends to submit claims.

BESTflex Plan FSA and EBC HRA Expenses

- When submitting claims for BESTflex Plan FSA expenses, similar services can be combined on a single line by using a range of dates. For example, you could use a single claim entry for a month of prescription expenses by completing the *Claim Form* as follows: Service Start Date: 01/01/2017, Service End Date: 01/31/2017, Description of Service: Prescription Co-pays.
- If you swiped your Benefits Card for an ineligible expense or do not have the substantiating documentation, you can offset the charge by submitting documentation for another FSA eligible expense that was not paid for with your Benefits Card and has not already been submitted for reimbursement. You can submit the offsetting claim by completing a claim form and typing "O" in the Benefit Code box, write in the Claim ID for the Benefits Card transaction you want to offset on the Description of Service line of the claim form, and attach a copy of the offsetting claim documentation.
- When submitting claims for EBC HRA expenses: claim the full eligible amount shown on your Explanation of Benefits (EOB) or receipt. We will automatically make any calculations necessary in accordance with your plan design.
- Refer to *My Company Plan* or your *Summary Plan Description* for the length of your runout period, which determines the number of days you have after the plan year ends to submit claims.

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Account Holder Information

To ensure timely and accurate claims processing, please complete the entire form.

Last 4 Digits of Social Security or Identification Number (Required)

First Name

Last Name

Email Address (we do not share your email address)

Employer

Claims

Benefit Codes: F Health Care FSA | L Limited Health Care FSA | D Dependent Care FSA | I Indv Billed Ins Premiums | H HRA | HF HRA first, then FSA | DC Debit Card Substantiation | O Offset Claim for an outstanding debit card purchase | LS Lifestyle Spending Account (LSA)

Enter one Benefit Code per claim line below.

Benefit Code
Service **Start** Date (mm-dd-yyyy)
Service **End** Dates (mm-dd-yyyy)
Description of Service
Provider
Person Receiving Service (Required for HRA)
$ **Claim Amount**
Service Provider Signature **(Dependent Care FSA and Lifestyle Spending Account (LSA) Only)**

Benefit Code
Service **Start** Date (mm-dd-yyyy)
Service **End** Dates (mm-dd-yyyy)
Description of Service
Provider
Person Receiving Service (HRA Only)
$ **Claim Amount**
Service Provider Signature **(Dependent Care FSA and Lifestyle Spending Account (LSA) Only)**

Benefit Code
Service **Start** Date (mm-dd-yyyy)
Service **End** Dates (mm-dd-yyyy)
Description of Service
Provider
Person Receiving Service (HRA Only)
$ **Claim Amount**
Service Provider Signature **(Dependent Care FSA and Lifestyle Spending Account (LSA) Only)**

Benefit Code
Service **Start** Date (mm-dd-yyyy)
Service **End** Dates (mm-dd-yyyy)
Description of Service
Provider
Person Receiving Service (HRA Only)
$ **Claim Amount**
Service Provider Signature **(Dependent Care FSA and Lifestyle Spending Account (LSA) Only)**

Claim Total: $

Claim Authorization

By submitting this form, I understand, agree to, and certify the following statements. This Claim Form is complete and correct. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year by eligible plan participants. These expenses have not been and will not be reimbursed by any other benefit plan or person, or claimed as an income tax deduction. These expenses are legal under state and federal law. Additional information may be requested from me in order to adjudicate my claim appropriately. I consent to the use and disclosure of my information in accordance with Employee Benefits Corporation's online privacy policy and applicable law solely for the purposes of administering my benefits as outlined in the agreement between my employer and Employee Benefits Corporation. If I am submitting a Lifestyle Spending Account claim, I certify the expenses listed above are not medical expenses and I understand reimbursements are in the form of taxable benefits.

By submitting this form I certify the above.