

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

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

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

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.

Service **Start** Date (mm-dd-yyyy)

Description of Service

Benefit Code

Service **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (Required for HRA)

\$

Claim Amount

Service Provider Signature (**Dependent Care FSA and Lifestyle Spending Account (LSA) Only**)

Service **Start** Date (mm-dd-yyyy)

Description of Service

Benefit Code

Service **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (HRA Only)

\$

Claim Amount

Service Provider Signature (**Dependent Care FSA and Lifestyle Spending Account (LSA) Only**)

Service **Start** Date (mm-dd-yyyy)

Description of Service

Benefit Code

Service **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (HRA Only)

\$

Claim Amount

Service Provider Signature (**Dependent Care FSA and Lifestyle Spending Account (LSA) Only**)

Service **Start** Date (mm-dd-yyyy)

Description of Service

Benefit Code

Service **End** Dates (mm-dd-yyyy)

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.

Direct Deposit Authorization

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

Complete and return this form to have EBC reimbursements deposited into your checking or savings account. Be sure to sign and date it. You can also authorize Direct Deposit by logging into your online account at www.ebcflex.com and choosing "Activate Direct Deposit" from the menu.

Authorization New Direct Deposit Authorization Change Direct Deposit Authorization Cancel Direct Deposit Authorization

Account Holder Information **Last 4 Digits of Social Security or Identification Number (Required)**

Last Name Suffix First Name MI

Email Address (we do not share your email address) Employer

Phone Number (000-000-0000)

Financial Institution Information

Financial Institution Branch

City State

MEMO: _____

1' 056073356 1: 5435732348 11'

Routing Number (Exactly 9 Digits) **Account Number**

Account Type: Checking Savings

Routing Number (exactly 9 digits from check) Account Number (from check)

*Please note that routing numbers starting with 5 are not valid for ACH deposits.
In most cases, the routing number precedes the account number. If in doubt, contact your financial institution.*

Depositor Certification

I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.

X

Account Holder Signature (Required) Date (mm-dd-yyyy)

Conditions of Participation

Participants have the option to have their EBC-authorized claim reimbursements deposited directly into their personal checking or savings account. It is an optional convenience called Direct Deposit. If you have any questions regarding your electronic transfers, call Participant Services at (800) 346-2126 or (608) 831-8445.

- If you decide to enroll in Direct Deposit, you must complete this authorization form or you may activate Direct Deposit within your online account at www.ebcflex.com.
- Direct Deposit applies to all accounts. This means any claim reimbursement processed by EBC will be deposited into your financial account automatically.
- The agreement represented by this authorization will remain in effect from one plan year to the next; there is no need to enroll each year. To cancel it, you must complete a new Direct Deposit Authorization Form as a cancel transaction or cancel within the Manage Direct Deposit page in your online account at www.ebcflex.com.

- It is your responsibility to notify us immediately of any changes in your financial institution (i.e. change of account number, closure of account, etc.). To notify us of a change, update your Direct Deposit information in your online account or use this Direct Deposit Authorization Form. Mark the "Change Direct Deposit Authorization" option in the Authorization section at the top of this form.
- Activating, changing, or deactivating Direct Deposit can take four business days to complete, please plan accordingly.
- Your electronic transfer will be made directly into your financial account. If your financial institution cannot make this transfer within three business days of receipt, we will investigate, then issue and mail a reimbursement check to you. Until the electronic transfer problem is resolved, you will continue to receive reimbursement checks in the mail. Reinstatement of Direct Deposit will be determined on a case-by-case basis and you will be notified if it occurs.
- Your financial institution may also cancel this agreement. In such cases, you will receive reimbursement checks in the mail.