Employee Benefits Corporation

Claim Form

Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126**, 608 831 8445, M - F 8:00 - 5:00 Central
E-mail support: **participantservices@ebcflex.com**

Welcome to our enhanced Claim Form. It's been redesigned to work with all your claims for both the BESTflex Plan and the EBC HRA. We hope you find it convenient to use.

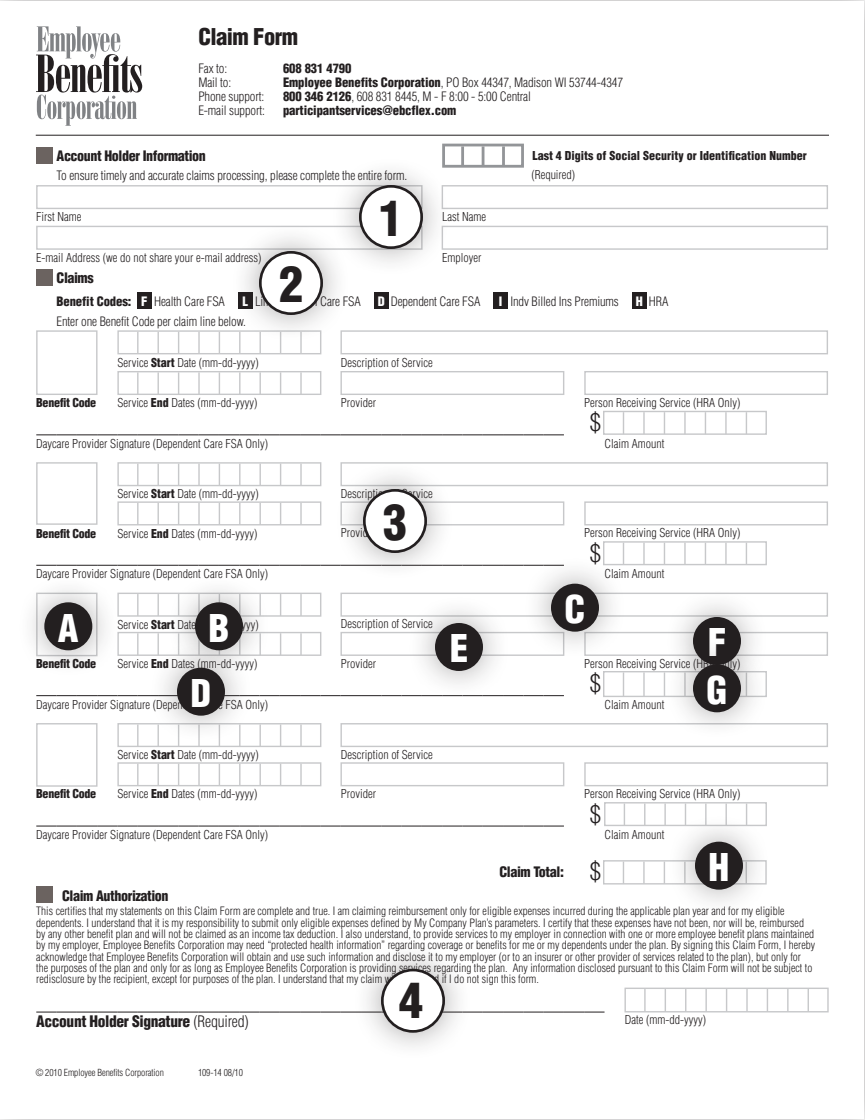
Please fill out this Claim Form completely. Be sure to enter the last 4 digits of your Social Security or Identification Number and your e-mail address.

E-mail provides the the most efficient means for us to communicate with you (we do not share your e-mail address).

Failure to complete the form in its entirety will delay processing your claim.

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 Indentification Number and your e-mail address.
2. Review the **Benefit Codes**.
3. Complete the **Claims Section**. If you submit multiple Claim Forms, be sure to include your name and the last 4 digits of Social Security Number on each form.
   - **A.** For each claim, be sure to include a "Benefit Code." Your claim cannot be processed without it.
   - **B.** If you're submitting a claim for services administered over a specific time period, be sure to include both the "Service Start and End Dates." Otherwise, simply complete the "Service Start Date," the date you received the service, bought the prescription, etc.
   - **C.** Enter a Description of Service, "Deductible," "Lab," "Daycare," "Prescription," etc.
   - **D.** If the claim is for daycare services (Dependent Care FSA Benefit Code "D"), you can use this Claim Form as a receipt for services without additional documentation by having your provider sign in the space provided.
   - **E.** Enter the name of the service provider.
   - **F.** For HRAs Only: Enter the name of the "Person Receiving The Service," you, your spouse, dependent child, etc.
   - **G.** Enter the claim amount.
   - **H.** Total the claim.
4. Sign and date the Claim Form.



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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 | E-mail Address (we do not share your e-mail address) | Employer

Claims

Benefit Codes: **F** Health Care FSA **L** Lif[illegible] Care FSA **D** Dependent Care FSA **I** Indv Billed Ins Premiums **H** HRA

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 (HRA Only) | Claim Amount $ | Daycare Provider Signature (Dependent Care FSA Only)

Claim Total: $

Claim Authorization

This certifies that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I understand that it is my responsibility to submit only eligible expenses defined by My Company Plan's parameters. I certify that these expenses have not been, nor will be, reimbursed by any other benefit plan and will not be claimed as an income tax deduction. I also understand, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, Employee Benefits Corporation may need "protected health information" regarding coverage or benefits for me or my dependents under the plan. By signing this Claim Form, I hereby acknowledge that Employee Benefits Corporation will obtain and use such information and disclose it to my employer (or to an insurer or other provider of services related to the plan), but only for the purposes of the plan and only for as long as Employee Benefits Corporation is providing services regarding the plan. Any information disclosed pursuant to this Claim Form will not be subject to redisclosure by the recipient, except for purposes of the plan. I understand that my claim [illegible] if I do not sign this form.

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

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Important information you need when submitting claims to Employee Benefits Corporation

- Please allow 3 business days from our receipt of your Claim Form before viewing the status of your account on www.ebcflex.com.
- 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 documention.
- Keep copies of all the Claim Forms and documentation you send to us.
- When submitting claims for 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: 01/01/2010, Service End Date: 01/31/2010, Description of Service: Prescription Co-pays.
- If we reissue a reimbursement to you because of a lost check, there is a $25 stop payment fee.

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Last Name

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Employer

Claims

Benefit Codes: **F** Health Care FSA **L** Limited Health Care FSA **D** Dependent Care FSA **I** Indv Billed Ins Premiums **H** HRA

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 (HRA Only)

$ Claim Amount

Daycare Provider Signature (Dependent Care FSA Only)

Benefit Code

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

Description of Service

Provider

Person Receiving Service (HRA Only)

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Account Holder Signature (Required)

Date (mm-dd-yyyy)

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