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

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 e-mail address.

2. Review the **Benefit Codes**.

   A. Enter the Benefit Code for your claim:

   [F] Health Care FSA - for BESTflex℠ Plan medical claims

   [L] Limited Health Care FSA for dental or vision claims if you have an HSA

   [D] Dependent Care FSA - for BESTflex Plan daycare claims

   [I] Individual Billed Insurance Premiums - for insurance premium claims

   [H] HRA - for EBC HRA claims

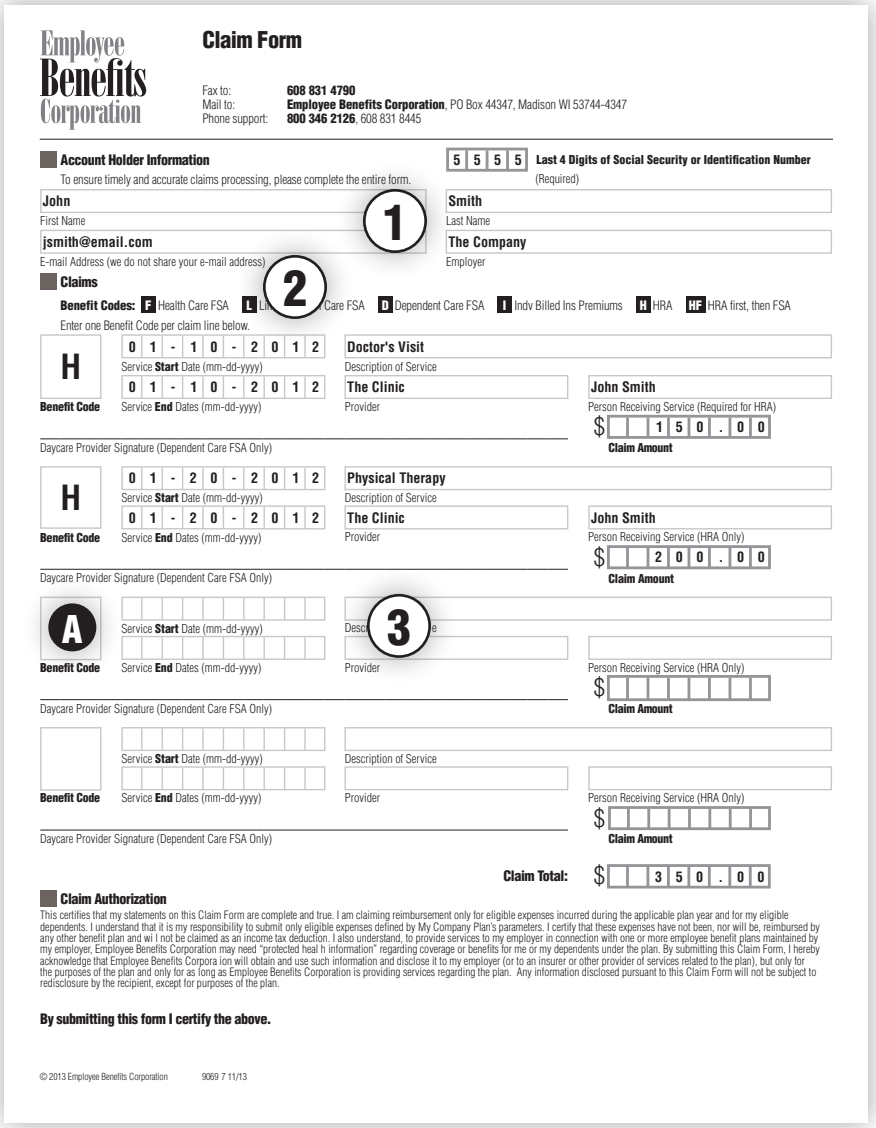
   [HF] ClaimsBridge - Process out of HRA first, then FSA. If your HRA plan allows rollover, this feature is not available. Please note, if HF is selected and the expense is not eligible in one of your plans, the whole amount will be processed from the eligible plan.

   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



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.
- 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.
- 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: 01/01/2010, Service End Date: 01/31/2010, Description of Service: Prescription Co-pays.
- 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.
- If you request that we reissue a claim reimbursement to you for any reason, there is a $25 stop payment fee.

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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** Limited Health Care FSA **D** Dependent Care FSA **I** Indv Billed Ins Premiums **H** HRA **HF** HRA first, then FSA

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

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

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

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

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 submitting 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.

By submitting this form I certify the above.

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