Employee Benefits Corporation

Claim Form

Submit Your Claim

Online: Log in to the mobile app, EBCentral, or your online account at www.ebcflex.com.

Fax: Fax completed claim form and required documentation (608) 831-4790.

Support

Phone: **(800) 346-2126** | (608) 831-8445

Email: **participantservices@ebcflex.com**

How to Complete the Claim Form

1. Complete the **Accountholder 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**.

   Enter the Benefit Code for your claim:

   - **[F]** Healthcare FSA (FSA that reimburses medical, dental and vision expenses)
   - **[L]** Limited healthcare FSA (FSA that reimburses dental and vision expenses)
   - **[D]** Dependent care FSA (FSA that reimburses day care expenses)
   - **[I]** Individual premium FSA (FSA that reimburses insurance premiums)
   - **[H]** HRA (HRA reimbursement)
   - **[HF]** Product linking (Allows expense to be reimbursed out of the HRA first, then the healthcare FSA/limited healthcare FSA. If your 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.

Set Up Direct Deposit

Get your money faster and have your reimbursement funds deposited electronically and securely in your checking or savings account. Setup direct deposit through the EBCentral mobile app or your online account.

Important information you need when submitting claims to Employee Benefits Corporation

- We will notify you when your claim is processed. You can always check the status of your claim in the mobile app or online account.
- Remember to send appropriate claim documentation with your form that verifies the expenses you are submitting for reimbursement. Claim documentation needs to 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 may be 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.

FSA and HRA Expenses

- When submitting claims for FSA expenses, similar services can be combined on a single line by using a range of dates. Enter the first date of expenses in the Service Start Date and the last date of expense in the Service End Date.
- If you swiped your Benefits Card for an ineligible expense or do not have the supporting 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 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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Accountholder 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 Healthcare FSA | L Limited healthcare FSA | D Dependent care FSA | I Indiv Premium FSAs | 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** Date (mm-dd-yyyy)

Description of Service

Provider

Person Receiving Service (Required for HRA)

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** Date (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** Date (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** Date (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.

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