Reimbursement Claim Form

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877.933.3539.

Section 1: Complete employee account information.

Employee Name:

Employee ID: (first initial, last name, last 4 digits of Social Security #)

Employer Name:

Email Address and/or Phone Number:

Section 2: Please list each eligible expense below.

Under the **Benefit Type** column, select one of the following benefit codes for each expense. We will then apply the expense to the appropriate account:

FSA - Flexible Spending Account
PARK – Parking
DCA - Dependent Care Account
LPFSA - Limited Purpose FSA
DVFSA – Dental Vision FSA
TRANSIT – Transportation
PRA – Premium Reimbursement Account
HRA/FSA - Apply to HRA first and FSA if applicable
ADA - Adoption Assistance

Recurring Payment	Paid with eflex Card	Benefit Type	Date(s) of Service *(From - To) Format: MM/DD/YY*	Description of Service	Provider/Merchant	Patient or Dependent Name & Birth Date	Dollar Amount
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
						Claim Total	

Section 3: Submit your claim form with supporting documentation via FAX to 877.231.1287 OR online via your employee portal, or the "eflex Benefits" mobile app.

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I or (we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person, who knowingly and with intent to injure, defraud or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law. Where indicated, parking amounts claimed are without an available receipt and this certification includes such expenses.

Signature:

Date:

eflex

Claim Form Instructions

Get your money fast in three easy steps:

1) Fill out the claim form completely and check to make sure your supporting documentation is complete and accurate.

It should include:

- Description of Service
- Date of Service
- Amount owed (after insurance has paid its portion)

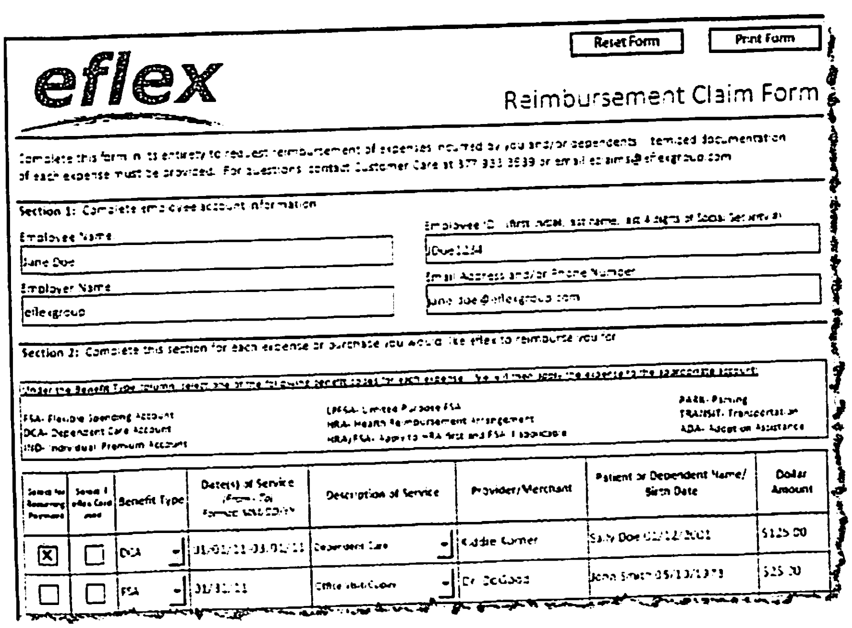
2) Sign and date your form.

3) FAX your claim with supporting documents to 877.231.1287, or submit online via your employee portal, or the "eflex Benefits" mobile app.

Get your claims paid faster:

- The fastest way to get reimbursed is to file your claim online. It's simple and takes less than 5 minutes to file and upload your receipt. Go to eflexgroup.com and click **File A Claim,** then **File Online** to get started.
- If you'd like to be reimbursed for on-going Dependent Care or Individual Premium expenses, fill out this claim form and select the **Recurring Payment** box. With proper documentation, you only file once but continue to be reimbursed throughout the year.
- Did you pay for your expense with your eflex Card? Don't forget to select **Paid with eflex Card** on the claim form.
- **Enroll in Direct Deposit.** It's the fastest, greenest and most reliable way to get your money back (form available online).

Claim and Documentation Examples


Reset Form Print Form

eflex Reimbursement Claim Form

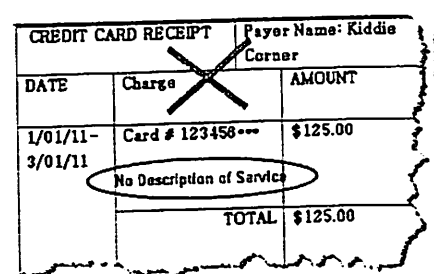
Section 1: Complete employee account information

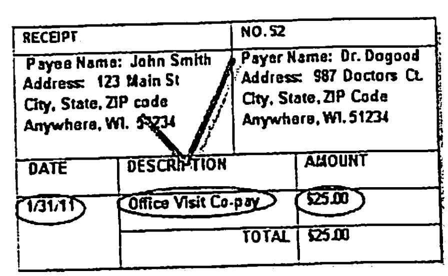
Employee Name: Jane Doe

Employer Name: eflexgroup

Section 2: Complete this section for each expense or purchase you would like eflex to reimburse you for

Select for Recurring Payment	Select if eflex Card used	Benefit Type	Date(s) of Service	Description of Service	Provider/Merchant	Patient or Dependent Name/ Birth Date	Dollar Amount
X		DCA	01/01/11-03/01/11	Dependent Care	Kiddie Corner	Sally Doe 02/12/2002	$125.00
		FSA	01/31/11	Office Visit/Copay	Dr. DoGood	John Smith 05/13/1973	$25.00


CREDIT CARD RECEIPT		Payer Name: Kiddie Corner
DATE	Charge	AMOUNT
1/01/11-3/01/11	Card # 123458••• No Description of Service	$125.00
	TOTAL	$125.00


RECEIPT		NO. 52
Payee Name: John Smith Address: 123 Main St City, State, ZIP code Anywhere, WI. 51234		Payer Name: Dr. Dogood Address: 987 Doctors Ct. City, State, ZIP Code Anywhere, WI. 51234
DATE	DESCRIPTION	AMOUNT
1/31/11	Office Visit Co-pay	$25.00
	TOTAL	$25.00