



Section 125 Administration

### Please Complete When Faxing:

Return Fax Number ^ \_\_\_\_\_ Date \_\_\_\_\_ No. of Pages \_\_\_\_\_

**Reimbursement Authorization:** This is to certify that my statements on this Reimbursement 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, EBC may need "protected health information" regarding coverage or benefits for me or my dependents under the plan. By signing this reimbursement form, I hereby acknowledge that EBC 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 EBC is providing services regarding the plan. Any information disclosed pursuant to this enrollment form will not be subject to redisclosure by the recipient, except for purposes of the plan. **I understand that my claim can be denied if I do not sign this form.**

### Reimbursement Form

Make a photocopy of this form

Please print

Fill out form completely

Staple all documents to the upper left corner of this form and mail to:

**Employee Benefits Corporation**  
PO Box 44347  
Madison WI 53744-4347

Or fax form and attachments to EBC at:

**608 831 1159**

When faxing, remember to fax copies of your bill or receipt, or Explanation of Benefits (EOB) for deductibles

**\$**  
Total amount of reimbursement requested \_\_\_\_\_ Date \_\_\_\_\_

### Signature

### My Personal Information:

First Name ^ \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ E-mail Address (We do not share your e-mail address) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Company Name \_\_\_\_\_

Check if any Personal Information is new or changed

### Health Care FSA:

Date of Service ^ \_\_\_\_\_ Type of Service \_\_\_\_\_ Name of Provider \_\_\_\_\_ Claim Amount \_\_\_\_\_

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Date of Service \_\_\_\_\_ Type of Service \_\_\_\_\_ Name of Provider \_\_\_\_\_ Claim Amount \_\_\_\_\_

### Dependent Care FSA:

Date of Service ^ \_\_\_\_\_ Type of Service \_\_\_\_\_ Name of Provider \_\_\_\_\_ Claim Amount \_\_\_\_\_

Date of Service \_\_\_\_\_ Type of Service \_\_\_\_\_ Name of Provider \_\_\_\_\_ Claim Amount \_\_\_\_\_

Date of Service \_\_\_\_\_ Type of Service \_\_\_\_\_ Name of Provider \_\_\_\_\_ Claim Amount \_\_\_\_\_

Date of Service \_\_\_\_\_ Type of Service \_\_\_\_\_ Name of Provider \_\_\_\_\_ Claim Amount \_\_\_\_\_



Web Address:  
www.ebcflex.com

U.S. Mail:  
Employee Benefits Corporation  
PO Box 44347  
Madison WI 53744-4347

Phone:  
Monday - Friday, 8:00 - 5:00  
608 831 8445  
800 346 2126

Fax:  
608 831 1159  
608 831 4790

**Reimbursement  
Form**

**How To Use The BESTflex Reimbursement Form**

For both Health Care FSA and Dependent Care FSA, please staple all receipts and expense documentation to the top left corner of the Reimbursement Form. Each requires special information that must be included in the expense documentation.

**For Health Care FSA, receipts and expense documentation must include:**

1. Date(s) of service
2. Type of expense (i.e., eye exam)
3. Amount of the expense incurred
4. Name of the service provider

**For Dependent Care FSA statements from your provider(s) must include:**

1. A statement from your provider listing:
  - a. Date(s) of service
  - b. Charges
  - c. Provider's signature

**OR**

A copy of your contract showing the required payments and periods of care

If you choose to send a copy of your contract, it must be sent to EBC once each plan year. Please indicate "Contract on file" with each request for reimbursement against that contract.

**Reminders:**

- EBC cannot reimburse you until expenses are actually incurred and you receive an invoice
- Provide proper documentation for all expenses submitted
- Sign AND date the Reimbursement Form
- Multiple expenses may be included on one form; attach additional forms if more space is needed
- Minimum reimbursement amount is \$10.00
- Additional forms and an envelope will be provided with your reimbursement check (or when a direct deposit is made)
- Retain original copies for your files
- You can obtain copies of all documents of the BESTflex Plan upon written request; there is a reasonable charge for copies
- IRS guidelines require EBC to maintain records of all claims and correspondence for seven years.