Claim Form Instructions

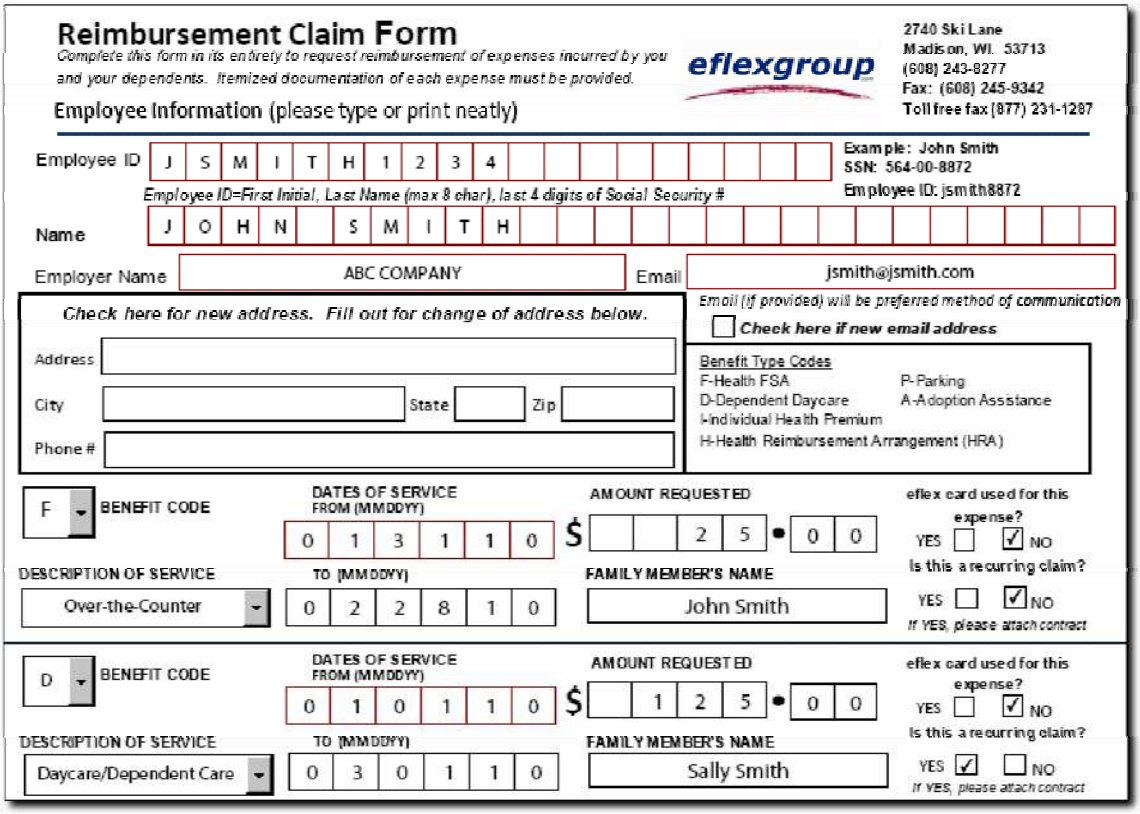
Complete this form in its entirety to request reimbursement of expenses incurred by you and your dependents. Please provide itemized documentation of each expense.

2740 Ski Lane
Madison, WI. 53713
Phone: (608) 243-8277
Toll free phone: 877-933-3539
Fax: (608) 245-9342
Toll free fax: (877) 231-1287

Helpful Hints to Get Your Claim Paid Fast without Delay

1. Please sign, date and complete required fields outlined in red on your eflex claim form.
2. Fax your claim with supporting documents, toll free at 877-231-1287 or mail to our address above.
3. All receipts, including credit card receipts, should include ***description, date of service and amount owed*** after the insurance has paid its portion**.**
4. **For Even Faster Payment**- Fill out, and include our direct deposit form found online at eflexgroup.com for direct deposit into your checking or savings account (optional).
5. Please keep copies for your records.

Claim & Receipt Examples



Reimbursement Claim Form

Complete this form in its entirety to request reimbursement of expenses incurred by you and your dependents. Itemized documentation of each expense must be provided.

2740 Ski Lane
Madison, WI. 53713
(608) 243-8277
Fax: (608) 245-9342
Toll free fax (877) 231-1287

Employee Information (please type or print neatly)

Employee ID: J S M I T H 1 2 3 4
Employee ID=First Initial, Last Name (max 8 char), last 4 digits of Social Security #
Example: John Smith
SSN: 564-00-8872
Employee ID: jsmith8872

Name: J O H N S M I T H

Employer Name: ABC COMPANY
Email: jsmith@jsmith.com
Email (if provided) will be preferred method of communication
Check here if new email address

Check here for new address. Fill out for change of address below.
Address:
City: State: Zip:
Phone #:

Benefit Type Codes
F-Health FSA
D-Dependent Daycare
I-Individual Health Premium
H-Health Reimbursement Arrangement (HRA)
P-Parking
A-Adoption Assistance

BENEFIT CODE	DATES OF SERVICE FROM (MMDDYY)	TO (MMDDYY)	AMOUNT REQUESTED	DESCRIPTION OF SERVICE	FAMILY MEMBER'S NAME	eflex card used for this expense?	Is this a recurring claim?
F	013110	022810	$25.00	Over-the-Counter	John Smith	NO	NO
D	010110	033010	$125.00	Daycare/Dependent Care	Sally Smith	NO	YES

If YES, please attach contract

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
1/31/10	Office Visit Co-pay	$25.00
	TOTAL	$25.00

CREDIT CARD RECEIPT

Payer Name: Kiddie Corner

DATE	Charge	AMOUNT
1/01/10–3/01/10	Card # 123456••• No Description of Service	$125.00
	TOTAL	$125.00

Reimbursement Claim Form

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Madison, WI. 53713
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Toll free fax: (877) 231-1287

Employee Information (please type or print neatly)

Employee ID

Employee ID=First Initial, Last Name (max 8 char), last 4 digits of Social Security No.

Example: John Smith
SSN: 564-00-8872
Employee ID: jsmith8872

Name

Employer Name

Email

Email (if provided) will be method of communication

☐ *Check here if new email address*

☐ *Check here for new address. Fill out for change of address below.*

Address

City State Zip

Phone #

Benefit Type Codes

FSA-Health FSA
DCA-Dependent Daycare
IND-Individual Health Premium
HRA-Health Reimbursement Arrangement
ADA-Adoption Assistance
LFSA-Limited Purpose FSA
PARK-Parking
TRAN-Transportation

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED
$.

PURCHASED WITH EFLEX CARD?
YES ☐ ☐ NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?
YES ☐ ☐ NO

If YES, please attach contract

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED
$.

PURCHASED WITH EFLEX CARD?
YES ☐ ☐ NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?
YES ☐ ☐ NO

If YES, please attach contract

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED
$.

PURCHASED WITH EFLEX CARD?
YES ☐ ☐ NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?
YES ☐ ☐ NO

If YES, please attach contract

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED
$.

PURCHASED WITH EFLEX CARD?
YES ☐ ☐ NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?
YES ☐ ☐ NO

If YES, please attach contract

TOTAL $.

***Note* Does your supporting documentation include the service date, service description and charge amount?** YES ☐ ☐ NO

(Credit card statements don't qualify as documentation according to IRS regulations).

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.

Signed By

Date