

# Flexible Spending Account (FSA)

*it's all about choices*



**eflex**

**fast answers | fast payments | web self-service**

## Design Your Savings

Grab your paycheck and look at your withholdings. Notice that money was deducted to pay state and federal taxes and to fund Social Security (FICA) taxes? The taxes you pay are translated into a percent of pay. This percentage is different in each state, but the average is 20 to 30%.

### Wouldn't it be great to cut your withholdings simply by setting money aside before taxes ?

With a Flexible Spending Account (FSA), that's precisely what you do. An FSA (also called a Cafeteria Plan) is an innovative benefit designed to save you money. Developed under IRS Section 125, it allows you to pay for certain health and dependent care expenses with pre-tax dollars. What's most unique is that it benefits both you and your employer.

**Simple.** Just determine a dollar amount that your employer will transfer to your FSA before calculating taxes each pay period. Any premiums you pay for group insurance through your employer will also be deducted from your gross pay before taxes are calculated. After the funds are transferred to your FSA, your gross income is lower (even though you have the money in another account), so the amount withheld for taxes is lower.

Use the money in your FSA to pay for certain out-of-pocket expenses like deductibles and coinsurance. And, if you're paying for dependent care each month, you can put pre-tax money aside to cover those expenses as well.

**THE BOTTOM LINE. With an eflexFSA, you have more money in your pocket each month.**



## Choose Your Plan

It just takes some simple planning. Remember, you're funding benefits based on future earnings. So when you design your plan, carefully estimate the costs you expect to incur in the coming year. Then, enhance your tax savings by enrolling in one or more of the following eflexFSAs.

- **Health FSA** pays for out-of-pocket medical expenses incurred during the plan year. Expenses covered under this account include insurance co-pays and deductibles, prescription drugs, diabetic supplies, eye glasses, dental services, orthodontics/braces, and more. Use the worksheet on the last page of this brochure to estimate how much you spend on medical expenses each year. Now imagine paying for those expenses pre-tax instead of after-tax. That's a savings of 28% for many people.
- **Dependent Care FSA** covers dependent day-care expenses while you (and your spouse) are at work. This eflexFSA covers your dependent children up to age 13 and elder dependents (like aging parents) who live in your home. You and your spouse must work or attend school to be eligible for a Dependent Care FSA. Please note that if you're divorced or separated, the IRS only considers the custodial parent eligible for this account.

**Debit Card.** We've made it easy to access your FSA. Just swipe the eflex Card like you would any credit/debit card at the time of purchase. We'll take care of paying the provider and deducting money from your FSA. In certain cases, you may need to submit documentation relating to your purchase.

Feel free to use your eflex Card at eligible day-care centers, doctor/dental offices, clinics, vision centers, and pharmacies as long as they accept MasterCard or VISA. Note: Debit Card not available in YPP plan

## How simple is that?

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## Select Your Tools

Enjoy our easy online services 24/7/365.

- View your account online
- View claims history
- Submit claims
- Sign up for Direct Deposit
- Choose for your eligible reimbursement to go directly to your provider

Account	Eligible Amount	Submitted Claims	Paid	Pending	Denied	Plan Year Balance	Available Balance
Health Plan 11	\$1,000.00	\$1,133.91	\$1,133.91	\$0.00	\$0.00	\$66.00	\$0.00
HRA Deductible 12	\$1,250.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,250.00	\$1,250.00

To access your secure account online:

- Open your web browser and type <https://employee.eflexgroup.com> into the address line.
- Enter your user name, which is typically your first initial, last name, and the last four digits of your Social Security number. (Example: John Smith 123-45-6789 is JSmith6789)
- If this is your first time logging onto the system, please refer to the "Next Step" documents you received at enrollment to obtain the default password. Once logged in, you will be prompted to create a new password for your account information.

View important account information on-the-go and **file claims directly from your smart phone or tablet** using the eflex Benefits mobile app for Apple and Android devices.

**Fast Claims.** To file claims, simply log into your eflex online account and either file electronically or download a claim form. Complete the form by listing your expenses, attaching or uploading your receipts, and signing and dating the form. We encourage you to complete a Direct Deposit form (available on our website). You may request a check for reimbursement, but direct deposit is the fastest way to get reimbursed; it saves paper and a trip to the bank.

**It usually takes just one to two business days to process your claim.**

The fastest way to receive reimbursement is to file online or fax us your completed claim form and receipts. Our toll-free fax number is 877.231.1287.

**Fast Answers.** When you have specific questions regarding your plan or our services, visit our website and Live Chat with one of our specialists. We'll get back to you with a prompt and helpful answer. You may also call or email our Customer Care Center 24 hours-a-day.

**The Fine Print.** After your plan year begins, you'll receive a Summary Plan Description, which details the plan selected by your employer. Because this is a pre-tax savings plan, it is subject to some IRS guidelines.

All expenses must fall within these guidelines to be considered "eligible" for reimbursement. So, please review your planning worksheet very carefully. This benefit can only pay for expenses incurred within the plan year. Expenses incurred in the previous plan year aren't eligible for payment under this plan even if you're paying for them in the new year. Orthodontia may be accepted as it is considered an on-going service.

**Founded on the idea that benefit plans should be easy, eflex is a different kind of TPA. With a customer focus and Lean Six Sigma quality tools, we are creating the highest standards of customer service in the industry.**

**Questions?** Visit our website at [eflexgroup.com](http://eflexgroup.com) or call us at 877.933.3539

**Great news! Your Flexible Spending Account (FSA) plan includes a \$500 carryover option or a 2.5 month extension**

## \$500 Carryover

### What does it mean for you?

The IRS decided to make the FSA program a whole lot better. They've done away with the "Use-or-Lose" rule, so you no longer risk losing your FSA dollars at the end of the year, or scramble to spend your remaining funds.

### How does it work?

With the new \$500 option, you can carryover up to \$500 of your unused FSA funds at the end of each plan year. Don't panic, there's no catch. You can still use your flex dollars to pay for eligible medical expenses.

Please review your Summary Plan Description to see if your plan includes the Carryover or 2.5-Month Extension.

### Still unsure?

Don't be. FSAs are a great way to stretch your benefit dollars and increase your overall spendable income. The money you put into an FSA is not taxed, so assuming you pay a combined 40% state and federal tax rate, you're saving 40% off healthcare expenses funded through the account.

If you choose not to participate in the FSA program because of the "Use-or-Lose" mandate, it's time to take another look.

## 2.5 Month Extension

### What does it mean for you?

The 2.5-month extension gives you greater peace of mind. Forgot to use your unused FSA funds at the end of your plan year? No problem. With an extension, you have 2.5 months after the close of the plan year to use your flex dollars.


### Example:

If your plan runs the calendar year (January through December), you have until March 15 to use your flex money and file claims for any expenses. How awesome is that?

**We told you it was great.**



**Questions? Let's talk.  
877.933.3539**




**We stay with you, even on the go.**






Apple & Android

**The eflex Benefits mobile app allows you to access important account information on-the-go 24-hours a day, 365 days a year**

**With our mobile app, you can:**

- File claims using your mobile device camera. Simply take a picture of your receipt and upload.
- View all of your account(s) information in one place
- Keep track of any changes to your account balance
- See your plan's end date and grace period
- View claims history
- Check the status of a claim
- See payment status
- Check for claim denials
- Totally secure access



**To download, visit the Apple App store or Android Marketplace and search "eflex Benefits."  
Take us with you.**

## Recurring Claims

At eflex we believe in simplicity. That's why we'd like to make filing your FSA claims as easy as possible with our recurring claims options.

A recurring claim allows you the freedom to submit your claim only once, but continue receiving reimbursements throughout the plan year. You may set up your Dependent Care and Orthodontic claims on recurring status.

To get your claim set up as recurring, select "Recurring Payment" on the claim form and submit a copy of your contract. Below is the information required for each type of recurring claim.

**Dependent Care:** Submit a completed eflex Dependent Care Contract. This form can be found on our website at [eflexgroup.com/forms](http://eflexgroup.com/forms). You'll need to submit a new contract each plan year. **Dependent Care claims can only be paid with funds that are currently available in your FSA at the time of the claim.** The balance of the claim will continue to release as you contribute more funds to your account.

**Orthodontic:** Submit a completed eflex Claim Form and a copy of your orthodontic contract. The contract needs to show the charges, description of services, dates of service (can be a date range), and name of the patient. You'll need to submit a new contract each plan year.

Recurring payments will begin after the start of the new plan year.



Your claim form and contract can be sent to us via email, fax, or mail. Once we receive your contract, we'll automatically generate a payment without any more effort on your part. For the fastest payment, we recommend signing up for direct deposit. Visit [eflexgroup.com/forms](http://eflexgroup.com/forms) and click on Direct Deposit form.



**Get your money back faster.**



## Here are a few ways to speed-up the reimbursement process

**Complete, sign, and date an eflex claim form.** You can find a claim form at [eflexgroup.com/forms](https://eflexgroup.com/forms). Be sure to include the covered employee's information (typically first and last name with the last four digits of his/her Social Security Number) on your claim form and all related documentation.

**Complete a Direct Deposit form.** Direct deposit to your checking or savings account will speed the reimbursement process and save you a trip to the bank. You only need to complete the Direct Deposit form once, unless you change banks or account information.

### **Attach receipts to document the expenses on your claim form:**

- Send an itemized statement or an Explanation of Benefits (EOB) from your insurance carrier. We can't process your claim from a credit card slip because it doesn't show all of the IRS-required information. At a minimum, we need the date of service, a description of the service, the service provider, and the amount owed.
- Don't send a statement showing "Balance Forward." The IRS says we need documentation showing the type and nature of service, the date of the service, and the amount owed (for that service). A balance-forward statement usually shows only the dollar amount so it doesn't meet IRS requirements.

**Submit claims for services you receive in the current plan year, not the previous year.** Your plan year and the date of the service (not billing date) must coincide, unless your plan offers a carryover option. Contact your employer to find out your plan options.

### **Use one of five methods to get your reimbursement:**

1. Complete our online claim form and scan your documentation. When you file online, you may choose to have payment sent to you or directly to your health care provider.
2. Upload using your smart phone or tablet.
3. FAX your claim form with documentation.
4. Email your claim form with scanned documentation.
5. Download and print out our claim form at [eflexgroup.com](https://eflexgroup.com) and mail it to us with documentation.

**Note:** *Don't forget to send all of your items together when possible. If we receive the claim form and documentation separately, there's no guarantee that we'll get them in sequential order or be able to quickly match them up. Because we often receive thousands of claims per day, you can help expedite the processing of your claim by remembering this simple step.*

**Q: What's the best way to determine how much to elect for my eflexFSA? Is there a minimum or maximum election?**

A: Review your check registers, end-of-year credit card statements or receipts from the previous year. It will help you to determine how much you've spent on eligible FSA expenses. You may also use our planning worksheet to help determine your election amount. The maximum election amount for your eflexFSA is determined by your employer and can be found in your Summary Plan Description. The IRS also limits contributions to \$2,550. The maximum election for the Dependent Care FSA is \$5,000 for head of household or married couples filing joint tax returns. It's \$2,500 for married couples filing separate tax returns.

**Q: Where can I find a list of eligible eflexFSA expenses?**

A: You can find a summary of eligible expenses on our Personal Planning Worksheet in this brochure. You may review a guideline of eligible expenses (Health Care Expenses Table) when you log into your eflex account online.

**Q: If I'm the primary accountholder, can I be reimbursed for my spouse's out-of-pocket medical expenses, too?**

A: Yes. If you have a Health FSA, you can be reimbursed for medical expenses incurred by you, your spouse, and your tax dependents. If you work for the same company and are both enrolled in the eflexFSA, you may also submit claims against each other's account.

**Q: Am I able to make adjustments to my eflex Flexible Spending Account (FSA) during the plan year, i.e., adjust my account election or enroll in another account such as the Dependent Care FSA?**

A: Changes to your eflexFSA account, including changing your annual election, can only be made if there's a qualified change of status. The IRS determines what's considered a qualified change of status. Examples of qualified changes in status include: birth, death, divorce, or marriage. For more information on IRS status changes, please visit the change of status calculator at [eflexgroup.com/tools](http://eflexgroup.com/tools).

**Q: What if I incur a large expense at the beginning of the plan year that will use funds I don't yet have in my eflexFSA?**

A: Under the "uniform coverage rule" created by the IRS, we'll pay the entire amount up to your maximum annual election, even if you don't yet have the entire amount in your health FSA. Your payroll deductions will continue throughout the plan year, even though funds have already been spent. Under the Dependent Care FSA, however, you're only eligible to spend funds that are actually accrued in your account up to your maximum annual election. The uniform coverage rule doesn't apply to dependent care.

**Q: What is the eflex Card?**

A: The eflex Card is a debit card that's tied to your eflexFSA. You may pay your health care providers directly using the eflex Card with funds from your eflexFSA. Just swipe the eflex Card like you would any credit/debit card at the time of purchase. We'll take care of paying the provider and deducting money from your FSA. (In certain cases, you may need to submit documentation relating to your purchase so keep your receipts.) Feel free to use your eflex Card at eligible day-care centers, doctor/dental offices, clinics, vision centers and pharmacies as long as they accept MasterCard or VISA. Note: debit card not available in YPP plan

**Q: What if I purchase an eligible expense with the debit card that's more than my annual election or what I have left to spend in my eflexFSA?**

A: The amount you have in your eflexFSA is your available balance on the eflex Card. You may use the eflex Card up to this amount, but never over. If you make a purchase for an amount over your available balance, the entire purchase will be denied. For example, if you have \$75 in your account, and you try to make a purchase for \$100, the entire transaction will be denied. If you know your available balance ahead of time, you can ask the store clerk to run your card for that amount, then use another form of payment to cover the rest. We recommended you check your account balance frequently. You can check your account balance 24-hours a day at [eflexgroup.com](http://eflexgroup.com) or on your mobile device. Note: debit card not available in YPP plan



## Frequently Asked Questions

**Q: What's the process for submitting documentation after I have used my eflex card? Do I always have to submit documentation? What do I do if I have lost my documentation?**

A: There will be times when we'll require a receipt for claim substantiation to comply with the IRS guidelines even for debit card purchases. Your receipt must include the date of service, the dollar amount, and a description of service. It's best to send an itemized bill or an Explanation of Benefits (EOB) from your insurance carrier.

If we do need a receipt for an eflex Card purchase, we'll send out two notices. If we don't receive the receipt/documentation after 45 days, we'll have to temporarily deactivate your eflex Card until we receive the complete substantiation required by the IRS. Please make sure we have your current email address. If we need a receipt for a debit card purchase, we'll send you an email after the debit purchase is made. Documentation can be sent to us via fax, email, or mail.

Many major retail outlets are now required to code their registers to identify and approve flex-eligible items at the point of purchase. In most cases, we won't ask for receipts eligible flex purchases as long as you shop at an approved location. Please visit [www.sig-is.org](http://www.sig-is.org) for the most current IIAS list of participating stores.

If you've lost documentation for an eflex Card purchase, you can contact the vendor for a reprint of your receipt.

**Q: Why do you sometimes ask for receipts when it's clear that the service I received was from my doctor or dentist?**

A: Sometimes the bill from your doctor or dentist doesn't provide us with enough information to determine whether the services you received are eligible for reimbursement. For example, you may purchase cosmetic services, like teeth whitening from your dentist or liposuction from your doctor that aren't covered under your eflexFSA, or the date of service may not be included in the information we receive. It's best to send an itemized statement or Explanation of Benefits (EOB) from your insurance carrier.

**Q: How do I get reimbursed for my expenses if I don't use the eflex Card?**

A: You'll need to submit a claim form and documentation. Claim forms can be found at [eflexgroup.com/forms](http://eflexgroup.com/forms). Once you've completed the claim form, attach the documentation (itemized receipts) and send it to us via fax, email, or mail. You may also file your claims electronically through your eflex online account at [employee.eflexgroup.com](http://employee.eflexgroup.com). Follow the instructions on the page to access your account. If you have a smart phone or an iPhone, you may download the eflex Mobile App and upload your claims and receipts using the camera on your phone!

**Q: How long will it take for my claims to be processed and reimbursed once they have been submitted to eflex?**

A: Claims are typically processed within 1-2 business days. We reimburse both checks and direct deposit payments daily.

**Q: Do you offer direct deposit for claims payments?**

A: Yes. Direct deposit is our preferred method of payment and is offered at no charge. You'll receive payments by direct deposit faster and cut down on costs and paper use as well. Direct deposit forms can be found at [eflexgroup.com/forms](http://eflexgroup.com/forms).

**Q: If my employment is terminated during the plan year, am I allowed to claim expenses incurred through the remainder of the plan year?**

A: No. If you terminate your employment, eligibility under your eflexFSA ends on your last date of employment. You'll only be able to submit claims for services incurred prior to your date of termination.

**Q: What happens to unused funds in my FSA plan?**

A: It's important to plan carefully so you don't have money left over in your account at the end of the plan year. Contact your employer to see if your plan offers a 2-½ month extension or carryover option to give you more time to spend-down your account.

**Q: What if I have questions about my eflexFSA?**

A: Call us toll-free at 877.933.3539, email [customercare@eflexgroup.com](mailto:customercare@eflexgroup.com), or LiveChat with us at [eflexgroup.com](http://eflexgroup.com). You may also manage your account online at [eflexgroup.com](http://eflexgroup.com)



## Two Words: Tax Savings.

The eflex FSA is like giving yourself a raise. It lets you take advantage of current tax laws by allowing you to pay for medical, dental, and vision care services with pre-tax dollars. You can also set aside money for dependent care expenses before taxes are calculated.

On the graph to your right, take a look at how the eflexFSA gave this employee a monthly raise. The employee actually took home \$168 more each month (\$2,016 annually) by enrolling in the eflexFSA.

	No FSA	FSA
Gross Monthly Income	\$3,500	\$3,500
Pretax Medical, Dental, Vison Expenses	\$0	\$200
Pretax Daycare Expenses	\$0	\$400
<b>Taxable Income</b>	<b>\$3,500</b>	<b>\$2,900</b>
Withholdings (28% for taxes, FICA and Medicare)	\$980	\$812
Post-tax Medical Expenses	\$200	\$0
Post-tax Daycare Expenses	\$400	\$0
	<b>\$1,920</b>	<b>\$2,088</b>

## Eligibility

Have you been offered group health coverage through your employer or through another employer this year?

- Yes.** You may elect the general purpose Health FSA which allows you to contribute tax free dollars to use toward eligible medical, dental, and vision care expenses. You may also elect the Dependent Care FSA.
- No.** You may elect a dental/vision FSA which allows you to contribute tax free dollars to use toward dental and vision care expenses. You may also elect the Dependent Care FSA.

## Interested? Here's How it Works

1. Simply estimate what you would spend on eligible medical expenses, daycare services, and/or dental and vision care. Only put into the eflexFSA what you'll realistically spend.
2. Enroll online at eflexgroup.com.
3. Starting with the first pay period of your plan year, your employer will automatically deduct the amount you elected each pay period from your gross wages (before taxes) and place into your eflexFSA.
4. When you incur eligible expenses, submit a claim form with documentation showing the service, description, and charges. You may file your claim online, upload it using your smartphone, email, FAX, or send to us via mail. *If you have the eflex Card, you can simply pay for the service with the eflex Card instead of a check or cash. It works just like a credit card. Daycare expenses can only be reimbursed according to the balance in your account.*

**Give yourself a raise. Enroll today!**



Use this worksheet to estimate expenses for you, your spouse, and eligible dependents. Then, simply transfer your plan-year total for each section to the tax calculator at [eflexgroup.com](http://eflexgroup.com) to discover your tax savings. If you participate in your employer's insurance plan(s), premiums will automatically be deducted pre-tax, unless you notify your Human Resource Department differently. ***This is not an enrollment form.***

## HEALTH RELATED EXPENSES

\$ _____	Doctor office visits co-pays	\$ _____	Alcoholism treatment
\$ _____	Deductibles	\$ _____	Ambulance
\$ _____	Routine physical	\$ _____	Medical Supplies (bandages, crutches, first-aid, etc.)
\$ _____	X-Rays	\$ _____	Sunscreen SPF 15
\$ _____	Breast Pump	\$ _____	Chiropractic visits
\$ _____	Dental co-pays	\$ _____	Care for handicapped
\$ _____	Dental deductibles	\$ _____	Diabetic supplies/insulin
\$ _____	Non-cosmetic dental services	\$ _____	Acupuncture
\$ _____	Orthodontia	\$ _____	Drug addiction treatment
\$ _____	Dental surgery	\$ _____	Guide animal care
\$ _____	Dental x-rays	\$ _____	Eligible hospital charges not covered by insurance
\$ _____	Contact lens & supplies	\$ _____	Lab fees
\$ _____	Laser eye surgery	\$ _____	Prescription expenses (co-pays)
\$ _____	Eye glasses	\$ _____	Prosthesis
\$ _____	Vision x-rays	\$ _____	Wheelchair(s)
\$ _____	Vision exams	\$ _____	Holistic healing services (if medically necessary)
\$ _____	Medical miles, paid according to IRS annual limits		

Health Plan Year Total \$

**Health-related expenses that require a letter of medical necessity or prescription include:** non-prescription vitamins • over the counter medicine • supplements from chiropractor, acupuncturist, holistic healer • Rogaine or hair transplant • Retin-A • electrolysis • health club memberships • massage therapy.

**Ineligible health-related expenses include:** • feminine hygiene products • dental bleaching or bonding • illegal operations or treatments • diaper service • meals that are not for inpatient care • marital or family counseling • services by a holistic healer who isn't licensed to practice medicine.

## DEPENDENT CARE EXPENSES

\$ _____	Day-care centers	\$ _____	Preschool
\$ _____	Elder care	\$ _____	After-school care
\$ _____	Family child care	\$ _____	Nanny/au pair
\$ _____	Day camps		

Dependent Plan Year Total \$

**Ineligible dependent expenses include:** meals • overnight camps • diapers • educational expenses including kindergarten • incidental fees such as activity fees and field trips, general health items such as toothbrush or toothpaste (even if prescribed by a dentist).

**Important:** You must list your dependent care provider's tax ID number on Form 2441 for your taxes each year. (\$5,000 maximum for married and head of household filers or \$2,500 if married filing separately.) Please refer to the Summary Plan Description if your spouse is a student or disabled. Also, you and your spouse (if applicable) must be gainfully employed to participate.

**Uncertain about whether an expense is eligible? Just go to our website at [eflexgroup.com](http://eflexgroup.com)**

# *eflex*



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**CONNECT**  
[eflexgroup.com](http://eflexgroup.com)

**EMAIL**  
[customercare@eflexgroup.com](mailto:customercare@eflexgroup.com)

**CALL**  
1.877.933.3539

**VISIT**  
2740 Ski Lane  
Madison, WI 53713



# Use or Disclosure Authorization

Complete this form to allow spouse, family members and/or agents to discuss your eflex account, claims, and other plan-related details with us.

By completing this Use or Disclosure Authorization, I hereby authorize eflex/eCOBRA the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to eflexgroup.com (eflex/eCOBRA).

I authorize the following person(s)/organization(s) to receive and/or discuss health information for me and my dependents.

Last name, First name	Relationship (e.g., spouse, agent, etc.)	Company (if applicable)	Disclose all health information? (Y/N) <i>If No, please provide specific description of information to be used or disclosed</i>

I understand the specific purpose of the disclosure may be made at the request of the authorized individual:  Yes  No

This authorization will expire upon termination of coverage. However, I may revoke authorization at any time by submitting written revocation to eflex/eCOBRA.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying eflex/eCOBRA, in writing, but the revocation will not have any effect on any actions that may have occurred before receiving the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- Information used or disclosed pursuant to this authorization may be re-disclosed by persons/organizations I have authorized to receive information. I have the right to seek assurances from the above-named persons/organizations that they will not re-disclose information to any other party without my further authorization.

Your Full Name (print) \_\_\_\_\_ Your SSN \_\_\_\_\_

Your Date of Birth \_\_\_\_\_ Employer Name \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please keep a copy for your records. Mail, email, or fax completed authorization to:**  
eflex Customer Care, 2740 Ski Lane, Madison, WI 53713  
f: 877-231-1287 | e: [customer care@eflexgroup.com](mailto:customer care@eflexgroup.com)



# 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) Email your claim with supporting documents to [eclaims@eflexgroup.com](mailto:eclaims@eflexgroup.com), submit online via your employee portal, the "eflex Benefits" mobile app, or FAX to 877.231.1287.

## 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](http://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, Orthodontia 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

**eflex** Reimbursement Claim Form

Complete this form in its entirety to request reimbursement of expenses incurred by you and/or dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877.933.3539 or email [eclaims@eflexgroup.com](mailto:eclaims@eflexgroup.com).

**Section 1: Complete employee account information**

Employee Name: Jane Doe Employee ID: (first initial, last name, last 4 digits of Social Security #) JDoe1234

Employer Name: eflexgroup Email Address and/or Phone Number: jane.doe@eflexgroup.com

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

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 LPFSA- Limited Purpose FSA PARK- Parking  
 DCA- Dependent Care Account HRA- Health Reimbursement Arrangement TRANSIT- Transportation  
 IND- Individual Premium Account HRA/FSA- Apply to HRA first and FSA if applicable ADA- Adoption Assistance

Select for Recurring Payment	Select if eflex Card used	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
<input checked="" type="checkbox"/>	<input type="checkbox"/>	DCA	01/01/11-03/01/11	Dependent Care	Kiddie Korner	Sally Doe 01/12/2001	\$125.00
<input type="checkbox"/>	<input type="checkbox"/>	FSA	01/31/11	Office Visit/Copy	Dr. DoGood	John Smith 05/10/1973	\$25.00

CREDIT CARD RECEIPT Payer Name: Kiddie Corner

DATE	Charge	AMOUNT
1/01/11-3/01/11	Card # 123456***	\$125.00
	No Description of Service	
	TOTAL	\$125.00

RECEIPT NO. 52

Payee Name: Dr. Dogood 123 Doctors Court Anytown, US 55555 Payer Name: John Smith 567 Main St. Any City, US 12345

DATE	DESCRIPTION	AMOUNT
1/31/11	Co-pay	\$25
	TOTAL	\$25



# Reimbursement Claim Form

Please complete this form to request reimbursement of expenses incurred by you and/or your eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877.933.3539 or email [eclaims@eflexgroup.com](mailto:eclaims@eflexgroup.com).

**Section 1:** Complete employee account information.

Employee Name:

Employer Name:

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

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	LPFSA - Limited Purpose FSA	PRA - Premium Reimbursement Account
PARK - Parking	DVFSAs - Dental Vision FSA	HRA/FSA - Apply to HRA first and FSA if applicable
DCA - Dependent Care Account	TRANSIT - Transportation	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
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<b>Claim Total</b>							<input type="text"/>

**Section 3:** Please sign, date and email the completed form to [eclaims@eflexgroup.com](mailto:eclaims@eflexgroup.com), submit online via your employee portal, the “eflex Benefits” mobile app, or FAX to 877.231.1287.

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:



# Flexible Spending Account (FSA) Enrollment Form

## Employee Information *(Please print clearly)*

Social Security No. \_\_\_\_\_ First Name, Middle Initial \_\_\_\_\_  
 Last Name \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_  
 Date of Hire (mm/dd/yyyy) \_\_\_\_\_ Area Code \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 email \_\_\_\_\_

### Employer to complete this section

Employer Name \_\_\_\_\_ Dept/Division/Client \_\_\_\_\_  
 Payroll Frequency \_\_\_\_\_ No. of Payroll Deductions \_\_\_\_\_ Hours per Week \_\_\_\_\_  
 Employee Plan Effective Date (mm/dd/yyyy) \_\_\_\_\_ Date of 1<sup>st</sup> Payroll Deduction \_\_\_\_\_  Short Plan Year  Full Plan Year

## Employee Elections *(Employee to complete the information below)*

Have you been offered health care coverage through your employer this year?

- Yes.** If yes, you may elect the full Health FSA which allows you to contribute tax free dollars to use toward medical, dental, and vision care expenses. You may also elect the Dependent Care FSA below.
- No.** If no, you may elect the DVFSA below which allows you to contribute tax free dollars to use toward dental and vision care expenses. You may also elect the Dependent Care FSA.
- I do not want to enroll.** If a change in status occurs, I may have the right to enroll in the plan at that time (if plan allows).

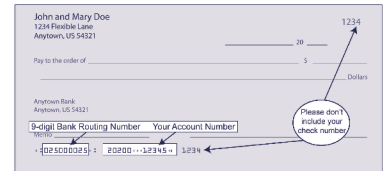
**A. Group Medical Premiums.** If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a tax free basis under this plan unless you notify your Human Resources or Personnel Department.

	Annual Election	Divided by (/) Number of Payrolls	Equals (=) Amount Per Pay Check	Employer Contribution <i>(if applicable)</i>	
				Per Month	Per Year
<b>B. Health FSA</b>	\$	/	\$	\$	\$
<b>C. Dependent Care FSA</b>	\$	/	\$	\$	\$
<b>D. DVFSA</b>	\$	/	\$	\$	\$
<b>E. LPFSA (available only with the HSA)</b>	\$	/	\$	\$	\$
<b>Totals</b>	\$	/	\$	\$	\$

**Direct Deposit Information** *(Complete this section if you are a new eflex customer or if your bank account information has changed in the past year. You don't need to complete this section if you had direct deposit in the last plan year and your bank account information hasn't changed.)* **IMPORTANT: Please provide a voided check (not a deposit slip) for each account listed below. We can't process without a voided check.**

Bank Name \_\_\_\_\_ Bank Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Name on the Account \_\_\_\_\_ Routing and Transit Number \_\_\_\_\_  
 Account Number \_\_\_\_\_ Account Type \_\_\_\_\_

With my signature below, I authorize reimbursements from my eflex plan to be sent to the financial institution named above to be deposited in the designated account. In the event funds are deposited erroneously into my account, I authorize eflex to debit my account(s) not to exceed the original amount of the credit. I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.



In setting up my eflex plan, I understand and agree that the IRS regulations state four conditions: 1) Any expenses I/we incur must be within the plan year; 2) Any expenses I/we incur must not be covered by any other source, such as insurance; 3) I/we must provide proper documentation to receive payment; 4) I/we cannot change or revoke elections during the plan year unless there is a specific change in status and my employer allows such changes. Please see the Summary Plan Description for details.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Send completed form with a voided check to your HR/Personnel Department**