EBS Benefit Solutions
An Excellus Company

Flexible Spending Account (FSA)
Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Claimant Name	Date of Service	Amount	Type of Service	Claim Ref #	EBS Use Only
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	01	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	02	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	03	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	04	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	05	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	06	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	07	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	08	

- For each claim, attach Explanation of Benefits (EOB), and/or itemized bill showing: date of service, provider name, patient name, charged amount and description. For Dependent Care, include the provider's tax id or SSN. **Do not send credit card receipts or cancelled checks**.
- Please be sure to provide your SSN or Member ID.
- Mail to EBS Benefit Solutions, FSA Dept, PO Box 22999 Rochester, NY 14692.
- For faster reimbursement processing, submit your claims online at www.myebsaccount.com.
- If covered by insurance, submit EOB or bill showing insurance payment.
- Submit one expense (either product or service) per row, even if items are contained on the same receipt. Each item must be itemized and must have a corresponding receipt. Label receipts to correspond to "Claim Ref #". If you have more than 8 items to submit, use additional Reimbursement Request Forms. *Note: Please do not "lump" or group items together or write "see attached". EBS can only process claims that are properly submitted. Claims will be returned to you unless they are properly submitted.*
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS, I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.

Flexible Spending Account Enrollment Form

For: ❑ Open Enrollment; Effective Date: _____ or ❑ New Hire; Hire Date: _____

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

FSA Benefit Type	Per Pay Period Amount	Total Annual Amount
Health Care Contribution	$.	$.
Dependent Care Contribution	$.	$.

# of Pay Periods per Year: _____ First Payroll Deduction Date: ____/____/_____

Automatic Claims Transfer (ACT): If you are eligible for ACT, certain out of pocket expenses may automatically be reimbursed to you (those that have been submitted through your insurance provider), unless you or any of your dependents have Coordination of Benefits (COB) with other Plans. If you are eligible, but do not want ACT, check the box, and you must submit your claims manually for reimbursement. *Note: ACT may be deactivated when your dependents attain a specified age (ie, age 19). Contact EBS Customer Service to verify the terms of your eligibility for ACT.* **This feature is not applicable to Flex Card Holders.**

❑ **I do not want ACT—or—I have COB and am not eligible for ACT.**

By submitting this form, I elect to participate in my Employer's Flexible Spending Account (FSA) Plan and agree to have my compensation reduced by the contributions indicated above for the Plan year. Any previous FSA election relating to the same benefits is hereby revoked. As a participant, I understand that:

- My Health Care and Dependent Care FSA contributions (indicated above) will be credited to my Health Care and Dependent Care FSA accounts. These contributions will reduce the amount of my compensation and are in addition to any premiums I pay on a pre-tax basis for Employer sponsored Health Insurance.
- I may file claims for reimbursement from my FSA accounts for qualified expenses incurred during the Plan year and after I have become a participant. I will forfeit amounts remaining in my FSA accounts after I am reimbursed for all expenses claimed through the period allowed under the Plan to file claims for expenses for the Plan year.
- I will pay the Employer for any tax liability or penalties it incurs if I am reimbursed for an expense that is not a qualified expense.
- I cannot change the amount of my FSA contributions or pre-tax health insurance premiums, unless I have a qualifying "life change" event as defined in the Plan and satisfy any other conditions for changes contained in the Plan and tax law.
- My FSA contributions will terminate when my employment terminates, unless I elect to continue my Health Care contributions on an after-tax basis, as allowed under COBRA.
- My Employer may change the amount of my FSA elections if necessary to satisfy tax law requirements.
- I understand that I must provide acceptable documentation for every claim I submit, including Flex Card purchases upon request.
- EBS Benefit Solutions, Inc. is not responsible for retaining copies of my receipts, beyond the current Plan year.

Participant Signature _____ Date _____

Return signed form to your Employer.

To Be Completed by the Plan Sponsor

- Notify Payroll of deduction amount and date
- Keep copy of Enrollment Form for your records
- Forward copy of Enrollment Form to EBS
- During Open Enrollment, consider reporting Employer funded money in a file to EBS

This Plan has employer funded money: ❑ Yes; ❑ No. If Yes, please complete:

ER Money:	Payroll Based?	Annual Amount
❑ Health Care	❑ Yes ❑ No	$
❑ Dependent Care	❑ Yes ❑ No	$

Direct Deposit Authorization Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Please check one:		
❑ Set up new Direct Deposit	❑ Change Direct Deposit	❑ Cancel Direct Deposit

Authorization Agreement for Direct Deposit Reimbursement

Bank Account Information:

Type of account: (*Please check one*)

❑ Checking — You must attach a ***voided check*** with pre-printed MICR account information, or a ***letter or form*** from the Bank certifying the ABA number, Account number and MICR information.

❑ Savings — You must attach a ***letter or form*** from the Bank certifying the ABA number, Account number and MICR information.

Name of Bank: _____

Transit ABA Routing #: _____ Account #: _____

(Please allow 10 business days after receipt by EBS Benefit Solutions, Inc. for bank pre-notification to be completed.)

- Direct Deposit is available only if your employer uses Electronic Funds Transfer.
- Please be sure to provide your SSN or Member ID.
- Mail to EBS Benefit Solutions, FSA Dept. 30 Perinton Hills Mall, Fairport NY 14450 or fax to 877-256-7228.
- Call Customer Service with questions at 800-327-7130.

By submitting this form, I hereby authorize EBS Benefit Solutions, Inc. to deposit my reimbursements directly into the back account indicated above and, if necessary, to withdraw amounts from the account in order to adjust for any amounts erroneously deposited. This authorization will remain in effect until EBS Benefit Solutions, Inc. receives written notice from me of its termination.

_____ _____

Participant Signature Date