Employee Benefits Corporation

Please Complete When Faxing:

Return Fax Number | Date (mm/dd/yyyy) | 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 Reimbursement 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.**

The EBC HRA®
Section 105 Administration

$ 0.00

Total amount of reimbursement requested | **Date (mm/dd/yyyy)**

X

Account Holder's Signature (Must be filled out by account holder)

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**

My Claim Detail:

Date of Service (mm/dd/yyyy)	Type of Service	Name of Provider	Claim Amount

Helpful Hints To Ensure Speedy Processing:

- 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
- Retain original copies of this form and documentation for your files; Reimbursement Forms, receipts and claims information cannot be returned
- Sign and date this Reimbursement Form. EBC will not process unsigned or undated forms
- Attach a copy of your Explanation of Benefits (EOB) for deductibles and coinsurance; for other eligible medical expenses you may submit the bill or receipt
- Documentation must include date(s) of services, type of expense, amount of expense and name of service provider

Reimbursement Form

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EBC Only

EBC Group ID Number

EBC Specialist

Processed Date

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 CST
608 831 8445
800 346 2126

Fax:
608 831 1159
608 831 4790

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