

Flexible Spending Account (FSA)

it's all about choices



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.

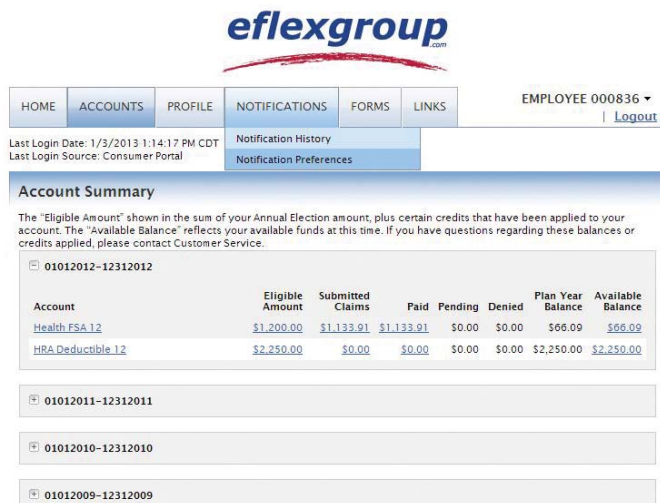
How simple is that?

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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



The screenshot shows the eflexgroup.com website interface. At the top, there's a navigation bar with links: HOME, ACCOUNTS, PROFILE, NOTIFICATIONS, FORMS, and LINKS. Below this, there's a section for "EMPLOYEE 000836" with a "Logout" link. The main content area is titled "Account Summary" and includes a table with columns: Account, Eligible Amount, Submitted Claims, Paid, Pending, Denied, Plan Year Balance, and Available Balance. The table lists two accounts: "Health FSA 12" and "HRA Deductible 12".

Account	Eligible Amount	Submitted Claims	Paid	Pending	Denied	Plan Year Balance	Available Balance
Health FSA 12	\$1,200.00	\$1,133.91	\$1,133.91	\$0.00	\$0.00	\$66.09	\$66.09
HRA Deductible 12	\$2,250.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,250.00	\$2,250.00

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 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. 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.

The image shows a "Dependent Care Contract" form from eflex. It includes fields for Employee Name, Date, Employee ID (first initial, last name, last 4 digits of Social Security #), and a section for Dependents for which care will be provided. There is also a section for "The provider charges \$" with radio button options for Weekly, Bi-weekly, Monthly, and Hourly. A "Reset Form" button is visible at the bottom right.

The image shows a "Reimbursement Claim Form" from eflex. It includes a "Reset Form" button at the top right. The form is divided into two main sections: Section 1: Complete employee account information, and Section 2: Please list each eligible expense below. Section 1 includes fields for Employee Name, Employee ID, Employer Name, and Email Address and/or Phone Number. Section 2 includes a table for listing expenses with columns for Itemizing, Item Code, Benefit Type, Description of Service, Provider/Manufacturer, Patient or Dependent Name & Birth Date, and Dollar Amount. A legend at the top of Section 2 defines various benefit types and codes.

Itemizing	Item Code	Benefit Type	Description of Service	Provider/Manufacturer	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"/>					

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 and click on Direct Deposit form.



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. 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 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.



How to avoid the most common eflex Debit Card mistakes

Use the card at designated Information Identification Approval System (IIAS) locations. Many major retail outlets, particularly pharmacies, are required to automatically identify and approve flex-eligible items. In most cases, we won't have to ask for receipts as long as you shop at an approved location.

The debit card will not work at restaurants, ATMs, or service stations. Use your card at any medical provider, clinic, hospital, vision center, dentist, and IIAS participating pharmacies.

If we request documentation for an eflex Card purchase:

- 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 required information.
- Don't send a "Balance Forward" statement. Per IRS regulations, we need documentation showing the type, nature of service, date of the service, and the charged amount. Balanced Forward statements do not meet these requirements.

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

Items that are not covered by FSA, but are needed to treat a specific medical condition require an eflex Letter of Medical Necessity (the eflex letter of medical necessity form can be found at www.eflexgroup.com/forms) Send the signed letter of medical necessity along with copies of your receipts and any other documentation to eflex.

Remember to check your eflexFSA account balance regularly at eflexgroup.com. If you make a purchase for an amount over the 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. By knowing your available balance ahead of time, you can ask the store clerk to run your card for a specific amount, and use another form of payment to cover the rest.

For a list of approved IIAS merchants, please visit eflexgroup.com/forms.

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 for 2016. 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.

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.

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 or on your mobile device.

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 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. 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. 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.

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, or LiveChat with us at eflexgroup.com. You may also manage your account online at 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, Vision Expenses	\$0	\$200
Pretax Daycare Expenses	\$0	\$400
Taxable Income	\$3,500	\$2,900
Withholdings (28% for taxes, FICA and Medicare)	\$980	\$812
Post-tax Medical Expenses	\$200	\$0
Post-tax Daycare Expenses	\$400	\$0
	\$1,920	\$2,088

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 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



A TASC[®] Division



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Madison, WI 53713
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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



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, 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 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
A TASC Division

Reset Form Print Form

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.

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:

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 4567 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.

Section 1: Complete employee account information.

Employee Name:

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

Employer Name:

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

PARK – Parking

DCA - Dependent Care Account

LPFSA - Limited Purpose FSA

DVFSA – Dental Vision FSA

TRANSIT – Transportation

PRA – Premium Reimbursement Account

HRA/FSA - Apply to HRA first and FSA if applicable

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"/>						
Claim Total							

Section 3: Please sign, date and email the completed form to 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 1st 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).

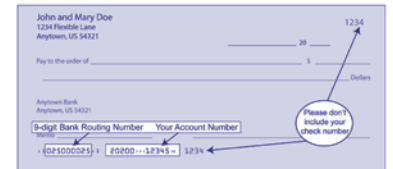
A. Group Medical Premiums. If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a tax free basis under this plan unless you notify your Human Resources or Personnel Department.

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

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