

COMPANY NAME _____

CLAIM FOR REIMBURSEMENT

EMPLOYEE NAME:		SOCIAL SECURITY #:
ADDRESS:		CITY:
STATE:	ZIP:	TELEPHONE #:

DEPENDENT CARE / ADOPTION ASSISTANCE EXPENSE CLAIMS

Name of Dependent(s)	Period Covered		Name, Address, SSN of Provider (Dep. Care)	Amount Incurred
	From	To		
Total Dependent Care/ Adoption Assistance Claim:				

Signature of Dependent Care Provider: _____

MEDICAL EXPENSE/HRA EXPENSE CLAIMS

Under new regulations – effective January 1, 2008 – you MUST include the condition being treated OR the prescription name when seeking reimbursement for a PRESCRIPTION DRUG.

Date Service Provided	Name of Service Provider	Condition Treated or Name of Prescription	Person for Whom Expense was Incurred	Net Amount
Total Medical Expense Claim:				

IF APPLICABLE - If you **do not** want to have EBSC pay for your medical expenses from the HRA Account after exhaustion of your medical expense reimbursement account, please initial here _____ otherwise, your expenses will automatically be paid from your HRA account after payment of all available funds from your medical expense reimbursement account.

As the participant in the above noted plans, I hereby authorize EBSC to discuss anything relative to the payment of any of these claims with _____, as my authorized representative.










READ CAREFULLY
The undersigned participant in the plan certifies (i) that all expenses for which reimbursement or payment is claimed (by submission of this form) are for services rendered and were incurred during a period while the undersigned was covered under the Cafeteria Plan or HRA Plan with respect to such expenses; and (ii) that he/she has not been reimbursed and will not seek reimbursement from another source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense. For Dependent Care reimbursement requests, the undersigned participant certifies that he/she is the custodial parent for the dependent child. In addition, the prescription drugs he/she is requesting reimbursement for are not for cosmetic purposes but are medically necessary.

Participant Signature: _____ Date: _____



Submit by sending to:
EBSC - Fringe Department
940 Industrial Drive South, Suite 111
Sauk Rapids, MN 56379; Phone: (800) 682-3826
Fax: (800) 889-3057
Scan and email forms to:
Claims@EBSC-online.org

INSTRUCTIONS FOR COMPLETING THE CLAIM REIMBURSEMENT FORM

1. Please complete your claim form as follows:
2. Medical Expenses, Day Care Expenses or Adoption Expenses
 -  Date the service was provided
 -  Name of the service provider
 -  A brief description of the procedure or expense
 -  Name of the person for whom the service was provided
 -  Amount claimed for reimbursement
 -  If you would like EBSC to reimburse this claim from your HRA Account (if applicable) you must indicate your election for EBSC to do so. Only after you have exhausted your annual election amount in your medical expense reimbursement account you can seek reimbursement from your HRA account by initializing the appropriate box.
 -  If you wish to allow EBSC to share information pertaining to this claim with individuals other than yourself (in case we need to explain what information is needed to help you get reimbursement for these expenses), you must designate an Authorized Representative on the form.
 -  Attach a copy of the insurance company's EOB and/or third party receipts for the expenditures for reimbursement of any expenses.
 -  Day Care Provider's signature is required
3. Read the statement regarding submitting your claim, located above the signature line. Sign and date the form.
4. When submitting a claim, include the **ORIGINAL** bill or receipt (when available) **and** EOB (Explanation of Benefits, from your insurance carrier) with your reimbursement claim form. Make a copy of the bill, receipt and EOB for your records. Submit the claim (using one of the following methods) to:

Mail:

EBSC
Fringe Department
940 Industrial Drive South
Suite 111
Sauk Rapids, MN 56379

E-mail:

Claims@EBSC-online.org

Fax:

(320) 257-8127
Or
(800) 889-3057

5. **The Employee is the only person eligible to sign the Reimbursement Claim Form!**

We cannot pay a claim without all of the above information.

If there is any other reason why we cannot make reimbursement to you, we will notify you in writing and you may resubmit the claim for reimbursement with the proper documentation.