Employee Benefits Corporation

# Individual Insurance Premium Claim Form

Madison Metropolitan School District

Phone support: **(800) 346-2126** | (608) 831-8445
Email support: **participantservices@ebcflex.com**

## How to Complete the Claim Form

1. Complete the **Account Holder Information** section in full.

   Be sure to include the last 4 digits of your Social Security or Identification Number and your email address.

2. Complete the **Claims Section**.

   Information **required** in order to process the claim:

   - Date of Service or Plan Year - both start and end date
   - Dollar amount for each line
   - Name of provider
   - Description of Service
   - Total dollar amount for the entire page

   If you would like to make an individual insurance premium claim recurring, enter the plan year start and end dates, fill in the monthly payment, and check the recurring claim box. Below is an example of how a recurring claim should be entered on the form. In this example a recurring claim has been established for a plan year of July 1 to June 30 with a monthly payment of $340.

## How to Submit the Claim Form

### Online

1. Log into your online account at www.ebcflex.com.
2. After you log in, click ***Submit a New Claim*** under ***Quick Links***.
3. Complete the online form, upload required documentation and submit.

### Fax

Fax the completed claim form and required documentation to (608) 831-4790.

### Setup Direct Deposit

Get your money faster and have your reimbursement funds deposited electronically and securely in your checking or savings account.

1. Log in to your online account at www.ebcflex.com.
2. After you log in, open the main menu.
3. Find the ***Manage*** section and click ***Direct Deposit***.

You may also download the *Direct Deposit Form* at www.ebcflex.com/forms. Simply complete the form and submit it with your *Claim Form*.

### Individual Insurance Premiums

07-01-2023
Service or Plan Year **Start** Date (mm-dd-yyyy)

Health Insurance Premium
Description of Service

06-30-2024
Service or Plan Year **End** Dates (mm-dd-yyyy)

Insurance Carrier Name
Provider

Person Receiving Service (Required for HRA)

✓ **Recurring Claim:** Additional documentation showing the plan year must be submitted or recurring claim processing will end on December 31.

$ 340.00
**Monthly Claim Amount**

## **Important information** you need when submitting claims to Employee Benefits Corporation

- If we have your email address on file, we will email you when your claim is processed. Please allow 2 business days from our receipt of your *Claim Form* before viewing the status of your online account in My Account Assistant (log in at www.ebcflex.com).
- Remember to send appropriate claim documentation with your form that substantiates the expenses you are submitting for reimbursement. Claim documentation must include the Provider Name, the Date(s) of Service, a Description of the Expenses incurred and the Expense Amount. Cancelled checks and non-itemized credit card receipts are not valid forms of documentation.
- **For recurring claims of individual insurance premiums**, documentation showing the monthly claim amount and plan year must be submitted with the claim form. This may be a combination of multiple documents such as an invoice and a photo of your insurance card. If documentation showing the plan year is not included the recurring claim processing will end on December 31.
- Retain original copies of the *Claim Form* and expense documentation for your files; Claim Forms, receipts and claims information will not be returned.
- If you request that we reissue a claim reimbursement to you for any reason, there is a $25 stop payment fee.

### Other HRA Expenses

If you have other eligible HRA expenses to submit for reimbursement, please submit your claim online or use the standard *Claim Form*.

### Online Claim Submission

1. Log into your online account at www.ebcflex.com.
2. After you log in, click ***Submit a New Claim*** under ***Quick Links***.

### Standard Claim Form

1. Download the *Claim Form* at www.ebcflex.com/forms.
2. Complete the form.
3. Fax the form and required documentation to (608) 831-4790.

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# Individual Insurance Premium Claim Form

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Email support: **participantservices@ebcflex.com**

## Account Holder Information

To ensure timely and accurate claims processing, please complete the entire form.

**Last 4 Digits of Social Security or Identification Number**
(Required)

First Name

Last Name

Email Address (we do not share your email address)

Employer

## Claims

Service or Plan Year **Start** Date (mm-dd-yyyy)

Description of Service

Service or Plan Year **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (Required for HRA)

**Recurring Claim:** Additional documentation showing the plan year must be submitted or recurring claim processing will end on December 31.

$

**Monthly Claim Amount**

Service or Plan Year **Start** Date (mm-dd-yyyy)

Description of Service

Service or Plan Year **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (HRA Only)

**Recurring Claim:** Additional documentation showing the plan year must be submitted or recurring claim processing will end on December 31.

$

**Monthly Claim Amount**

Service or Plan Year **Start** Date (mm-dd-yyyy)

Description of Service

Service or Plan Year **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (HRA Only)

**Recurring Claim:** Additional documentation showing the plan year must be submitted or recurring claim processing will end on December 31.

$

**Monthly Claim Amount**

Service or Plan Year **Start** Date (mm-dd-yyyy)

Description of Service

Service or Plan Year **End** Dates (mm-dd-yyyy)

Provider

Person Receiving Service (HRA Only)

**Recurring Claim:** Additional documentation showing the plan year must be submitted or recurring claim processing will end on December 31.

$

**Monthly Claim Amount**

If you have additional Individual Insurance Premium claims, please complete and submit a second form.
If you have other HRA eligible expenses to submit, please follow the instructions on page 1.

## Claim Authorization

By submitting this form, I understand, agree to, and certify the following statements. This Claim Form is complete and correct. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year by eligible plan participants. These expenses have not been and will not be reimbursed by any other benefit plan or person, or claimed as an income tax deduction. These expenses are legal under state and federal law. Additional information may be requested from me in order to adjudicate my claim appropriately. I consent to the use and disclosure of my information in accordance with Employee Benefits Corporation's online privacy policy and applicable law solely for the purposes of administering my benefits as outlined in the agreement between my employer and Employee Benefits Corporation. If I am submitting a Lifestyle Spending Account claim, I certify the expenses listed above are not medical expenses and I understand reimbursements are in the form of taxable benefits.

**By submitting this form I certify the above.**