BenefitWallet®

How to reimburse yourself by fax or U.S. Mail

If you made eligible purchases with your personal funds, you can reimburse yourself by fax or U.S. Mail. To do so, you will need a claim form, easily downloaded from the BenefitWallet member portal.

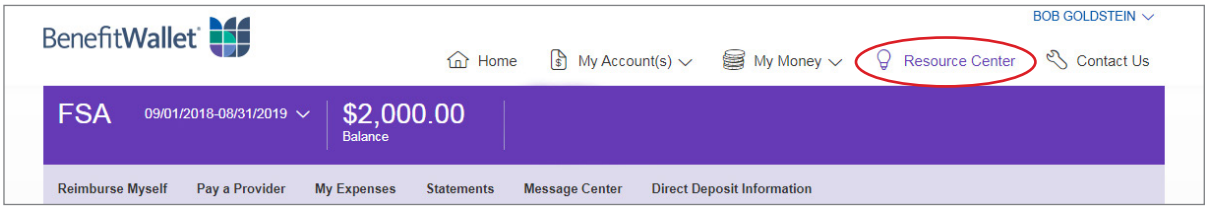
Step 1

Log in to the BenefitWallet member portal at **www.mybenefitwallet.com**.

- If you need to create a User ID and Password, click ***First Time User***.
- If you have forgotten your User ID, click ***Forgot User ID***.

Step 2

Once you've logged in, click ***Resource Center*** in the upper right corner of the home page.



Step 3

To download the FSA Reimbursement Form:

- In the Resource Center, locate ***Claim Forms*** on the right side of the page.
- Save the ***FSA Reimbursement Form*** to your personal computer and print it out.

Step 4

To finish the process of reimbursing yourself from your account:

- Complete the form and mail or fax using the information provided.
- Be sure to include proper documentation to substantiate your purchase as an eligible expense. **Proper documentation must include all of the information shown below**. Note: Credit card receipts are not proper documentation.

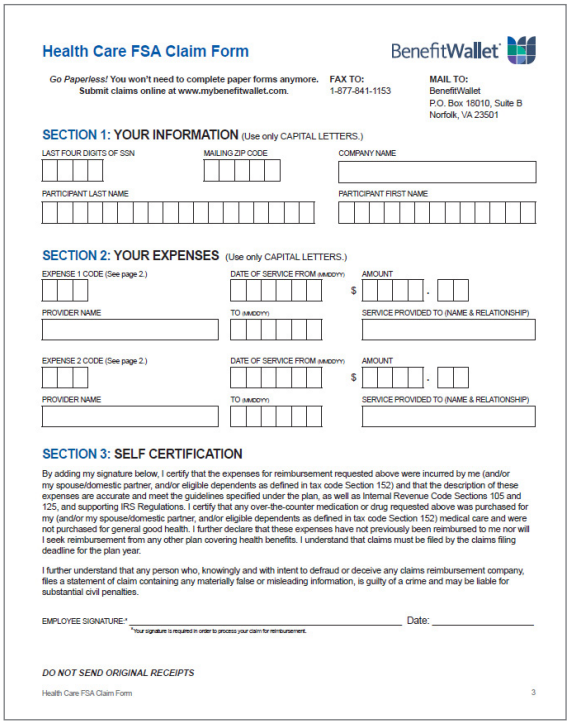
✓ Name of the person who incurred the service or expense

✓ Name and address of the provider or merchant

✓ Date the service or expense was incurred

✓ Detailed description of the service or expense

✓ Amount charged for the service or expense



Health Care FSA Claim Form BenefitWallet

Go Paperless! You won't need to complete paper forms anymore. Submit claims online at www.mybenefitwallet.com.

FAX TO: 1-877-841-1153

MAIL TO: BenefitWallet P.O. Box 18010, Suite B Norfolk, VA 23501

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS.)

LAST FOUR DIGITS OF SSN | MAILING ZIP CODE | COMPANY NAME

PARTICIPANT LAST NAME | PARTICIPANT FIRST NAME

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS.)

EXPENSE 1 CODE (See page 2.) | DATE OF SERVICE FROM (MMDDYY) | AMOUNT $.

PROVIDER NAME | TO (MMDDYY) | SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 2 CODE (See page 2.) | DATE OF SERVICE FROM (MMDDYY) | AMOUNT $.

PROVIDER NAME | TO (MMDDYY) | SERVICE PROVIDED TO (NAME & RELATIONSHIP)

SECTION 3: SELF CERTIFICATION

By adding my signature below, I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse/domestic partner, and/or eligible dependents as defined in tax code Section 152) and that the description of these expenses are accurate and meet the guidelines specified under the plan, as well as Internal Revenue Code Sections 105 and 125, and supporting IRS Regulations. I certify that any over-the-counter medication or drug requested above was purchased for my (and/or my spouse/domestic partner, and/or eligible dependents as defined in tax code Section 152) medical care and were not purchased for general good health. I further declare that these expenses have not previously been reimbursed to me nor will I seek reimbursement from any other plan covering health benefits. I understand that claims must be filed by the claims filing deadline for the plan year.

I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information, is guilty of a crime and may be liable for substantial civil penalties.

EMPLOYEE SIGNATURE* _____ Date: _____

*Your signature is required in order to process your claim for reimbursement.

DO NOT SEND ORIGINAL RECEIPTS

Health Care FSA Claim Form 3