FBMC
proven benefit solutions

EZ REIMBURSE® MasterCard® Card
RECEIPT TRANSMITTAL COVER SHEET
(instructions on back)

- Only use this cover sheet if you are mailing or faxing EZ REIMBURSE® Card receipts! Use a standard paper claim form when submitting receipts for non-card related transactions.
- FBMC will receive your FAX and secure the content according to the HIPAA Privacy requirements. Be sure that you or others working on your behalf secure your data at the point of origination.
- Attach copies of your documentation with this cover sheet.
- Make sure to keep copies of your original receipts.

Note: The participant is responsible for misrepresentation regarding requests for reimbursement. If you have any further questions please call 1-800-342-8017.

Employer Name_____**No. of Pages** _____

Fax to: FBMC, 850-425-4608

Mail to: Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, Florida 32302-1800

I certify that I am a person authorized to use the MasterCard® Card issued on behalf of the participant indicated on the card below and that by signing and using the card I agree to all of its terms and conditions. I understand that the card can only be used at merchants and service providers, properly coded as an eligible health care provider, that are authorized by my employer. I understand that any transactions initiated by my use of an authorized Card are subject to the terms and conditions of the Cardholder Agreement, and the Funds Transfer Disclosure Statement received with the Card. I certify that the qualified healthcare expenditures presented with this transmittal have been received by an eligible individual and are true and accurate. I certify that my card will be used to only pay for the IRS-qualified expenses permitted under my employer's Medical Expense FSA plan, for services incurred by me and my IRS-eligible dependents, during my period of coverage within the plan year, on the date(s) indicated on the attached documentation. I further certify I have not and will not seek reimbursement through any other source, and will exhaust all other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my FSA. I will collect and maintain sufficient documentation to validate my reimbursed FSA expenses. I will not claim any reimbursed FSA expense for any federal income tax deduction or credit. I understand further that the IRS requires that my Employer (or its designee) take corrective measures if an ineligible/unsubstantiated expense is reimbursed from my FSA, including denial of card access until the ineligible/unsubstantiated expense is recouped. I have read and understand the information on the front and back of this form.

_____ _____
Participant's Full Name Participant's Signature

_____
Participant's Social Security Number **Total Amount of Attached Receipts**

_____ _____
Participant's Work Phone Number Participant's E-mail Address

_____
Card Number (Last 10 digits)

Privacy & Confidentiality of Information Notice:
This communication contains Personal Health Information (PHI) intended for the sole use of the designated recipient(s).
If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply e-mail or by telephone, and delete all copies of this communication, including attachments, without reading them or saving them to disk.
If you are the intended recipient, you must secure the contents in accordance with all applicable state or federal