You have access to a Consumer Portal to check your balances and activity detail, view and enter claims and retrieve all communications from us online: https://epsiparticipant.lh1ondemand.com

Fringe Benefit Group

To file a claim:

1. Complete the form
2. Attach receipts
3. Fax, Mail, or Email

Fringe Benefit Group
2180 North Loop West
#400 Houston, TX 77018
Phone: (877) 227-1020 Fax:
(512) 222-1399
FSAclaims@fbg.com

Employee Cafeteria Plan

Reimbursement Voucher

Employer Name	Group No.
Employee Last Name, First	Date of Birth
Street Address, City & State	Zip Code
Phone Number	Identification Number

Claim Information

You must submit a receipt or Explanation of Benefits (EOB) from your provider or merchant with your claim form showing service dates & fees paid.

Date of Service:	Description of Service:	Claim Amount:	Service Recipient:
		$	
		$	
		$	
		$	
	Total:	**$**	

Reimbursement Guidelines

Note: Includes medical, dental, vision or other expenses eligible under the Cafeteria Plan and *not* reimbursed by any other health plan. Attach the itemized receipts for these expenses and/or the "Explanation of Benefits Form" you receive from your group plan.

Read Carefully:

- ✓ Fringe Benefit Group will rely upon information provided by the Participating Employee, and shall not be liable for the completeness or truth of any information supplied.
- ✓ Fringe Benefit Group shall have no obligation to any Participating Employee for any act, or failure to act, provided Fringe Benefit Group has acted in good faith in exercise of its powers as Claims Administrator of the Plan.
- ✓ The Participating Employee is responsible to maintain appropriate records and receipts for claims made under provisions of the Plan. Participating Employee may be required to supply proof of claims in the form of receipts or canceled checks.
- ✓ The Internal Revenue Service will also require verification in case of individual tax audit.

❑ By my signature below, I certify the reimbursements I am requesting are not eligible for payment under any other insurance plan.

Participant's Signature (Required) **Date**