CLAIM FORM – COMMUTER BENEFITS

1. Instructions (incomplete claim forms will not be processed)

- Complete the Employee / Employer Information requested under Section 2.
- Fully complete all fields in Section 3. **Claim forms with incomplete information will be rejected.** Please itemize each expense. Additional pages may be attached. Receipts must contain the dates of service, the name of the service provider, description of the expense and the amount.
- Under Section 4, read the Employee Authorization carefully and sign noting your agreement.
- **Keep complete copies of all receipts and forms submitted to EBS for audit purposes.** EBS is not responsible for providing copies to participants.
- Completed claim forms should be submitted in one of the following ways:
  1. **Fax: 925.460.3929 (preferred)**
  2. Email: claims@ebsbenefits.com or
  3. Mail: EBS, P.O. Box 11657, Pleasanton, CA 94588

2. Employer / Employee Information ❍ **New Address? Check the box if the address listed below is new**

Employer Name _____

Employee Name _____ **Last 4 of SSN** XXX-XX-____

Street Address _____

City / State / Zip Code _____ **Daytime Phone** _____

3. List of Eligible Expenses

Date of Service	Type of Expense	Amount Requested
1/1/12 – 1/31/12	TRANSIT OR PARKING	$125
	Total Amount Requested	

4. Employee Authorization

I certify that I have incurred expenses for which reimbursement is sought under my Commuter Benefits and that these expenses have been incurred during the plan year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program and that I am solely responsible for the accuracy of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Commuter Benefit plan.

Employee Signature _____ **Date** _____

5. Employee Release if Emailing Claims

According to the regulations as set forth by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have established the appropriate administrative, technical, and physical safeguards to prevent Protected Health Information (PHI) from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. The safeguards EBS has put in place include sending your supporting receipts, EOBs and claim forms through our secure fax or through US mail.

If you choose to send us your documentation containing PHI through email, you understand that such email is not secured and you are responsible for securing your information in an appropriate manner. Any transmission of your PHI through email may result in unauthorized disclosure of your PHI and, consequently, an exposure risk to you or your dependents. By sending us your claims via email and by signing the below, you understand that EBS is not responsible for any information transmitted by you or your agent on your behalf.

Employee Signature _____ **Date** _____