EZ REIMBURSE® MasterCard® Card
RECEIPT TRANSMITTAL COVER SHEET

- Only use this cover sheet if you are mailing or faxing EZ REIMBURSE® MasterCard® receipts! You do not need a cover sheet to fax your paper claim form and receipts.
- 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 receipts with this cover sheet.
- Make sure to keep copies of your original receipts.

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

Fax to: FBMC, 850-514-5817

Mail to: Fringe Benefits Management Company
P.O. Box 1810
Tallahassee, Florida 32302-1810

I certify that I am a person authorized to use the MasterCard® Card issued on behalf of the participant indicated below and that by signing and using my debit card I agree to all terms and conditions. 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 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.

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 requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.