

# How do I set up an account on FlexFacts.com?

## To register for your Flex Facts online account:

- 1 **Click here** or go to [www.flexfacts.com](http://www.flexfacts.com) > Participant Login > Register
  - 2 Set up your username and password
  - 3 Registration ID: choose 'Employer ID' and enter **GBSRIVBOE**
  - 4 Employee ID: enter your Social Security Number (no dashes)
  - 5 Click "View Terms of Use" and after reviewing, accept the terms and click Next
  - 6 Create your Security Questions and Answers to complete your registration
- + **Receive your reimbursements sooner** by enrolling in Direct Deposit (recommended)-
- ✓ Click on your name near the profile icon (top right corner of the page)
  - ✓ Click Edit near Reimbursement Method
  - ✓ Select Direct Deposit > Edit > enter your bank account information > Save



Once registered, you can submit claims online, access your account information including balances and claims history.

You can download our Mobile App to your Smartphone at the Apple iTunes store (iPhone) or the Google Play Store (Android) by searching for Flex Facts or scanning the QR codes.

To log in, use the same Flex Facts User ID and Password you created during registration.

The app can be used to view account balances, view transaction history and to upload claims by taking a picture from your smartphone.



Google



iPhone

## CONTACT US

Toll Free: 877-94-FACTS (32287)

Local: 732-640-5951

### Hours of Operation (excluding Holidays)

Monday – Thursday: 8:30 AM - 8:30 PM EST

Friday: 8:30 AM - 5:30 PM EST

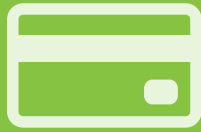
Email: [Info@flexfacts.com](mailto:Info@flexfacts.com)

Fax: 877-747-8564

Mail: 1200 River Ave, Suite 10E, Lakewood, NJ 08701



**FLEXFACTS**  
a company of grant benefit solutions



## When can I use my Flex Facts debit card?

The easiest way to use your funds is by using your Flex Facts debit card at the point of service. The card can be used at any medical or dependent care facility that accepts MasterCard. You can also use your card at most pharmacies. When you use your card funds are automatically deducted from your account to pay for eligible expenses.

Please note that you should retain all of your receipts. The IRS requires that we request copies of receipts for certain claims. If you are required to send in receipts an e-mail or letter will be sent to you the business day after you use your card.

If you are not able to use your card at the point of service you can file a claim online, by fax or by mail.



## How do I file a claim?

### **Filing Online:**

Log into your Flex Facts account, click on the "Claims" tab and choose "My Claim Activity", then click "Submit Claim" and follow the online instructions.

### **Email:**

Email your completed Claim Form and receipts to [claims@flexfacts.com](mailto:claims@flexfacts.com)

### **Mail/ Fax:**

Complete a Claim Form and send it along with a copy of the receipt/invoice to:

Flex Facts Claims Department  
1200 River Ave, Suite 10E  
Lakewood, NJ 08701

**Fax:** 877-747-8564



## When will I receive the claim reimbursement?

Manual claims are reimbursed via manual check or direct deposit. It generally takes 7-10 business days from the date the claim is processed, for the check to be received.



To speed up the reimbursement process, you can sign up for direct deposit. Funds are generally deposited into your bank account within 3-5 business days, from the date the claim is processed.



## How long do I have to submit claims?

Most plans allow 90 days after plan year end, to submit claims for expenses incurred during the plan year.

Accounts/cards will be deactivated upon termination of any kind. Employees generally have 90 days from date of termination to submit claims for expenses incurred during active participation in the plan.

Refer to your Plan Documents for specific plan details.



Please send this form along with all applicable receipts to:

Flex Facts, Inc., 1200 River Avenue, Lakewood, NJ 08701  
Fax: 877-747-8564  
E-Mail: Claims@flexfacts.com

## Flexible Spending Account Claim Form

### Personal Information

Employer: \_\_\_\_\_  
Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*  
Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Please update my address on file to the new address listed below:

\_\_\_\_\_ *Street Address* \_\_\_\_\_ *Apartment/Unit #*  
\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *ZIP Code*

### Claim Information

Please enter the claim information and amount you are seeking reimbursement for:

Provider Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**IMPORTANT:** Please be sure to submit an itemized receipt for each service listed above.

### Direct Deposit Information

**Enroll in Direct Deposit to receive your claim reimbursement within 3-5 business days from date the claim is processed.**

Bank Name: \_\_\_\_\_ Account Type: \_\_\_\_\_  
Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

I authorize Flex Facts to initiate debits and/or credits to or from my bank account indicated above. Debits will only be initiated in order to correct a prior reimbursement error. My authorization will remain in effect until I provide a written notification of the termination of this authorization or change my direct deposit information on-line. A reasonable amount of time will be provided for Flex Facts to apply any changes requested.

### Employee Authorization

- If additional information is required you will receive a denial letter letting you know what additional information is needed.
- Claims incurred during a grace period will be paid out of the prior year first.
- Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact your employer to see if advance payments for orthodontia expenses are allowed.
- By signing this form, I consent to/ confirm:
  - ✓ My account being reduced by the amount requested above.
  - ✓ This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
  - ✓ These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Please send this form along with all applicable receipts to:

Flexfacts, Inc., 1200 River Avenue, Lakewood, NJ 08701  
Fax: 877-747-8564  
E-Mail: Claims@flexfacts.com

## Dependent Care Account Claim Form

### Personal Information

Full Name: \_\_\_\_\_  
*Last* *First* *M.I.*

Employer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

If your address has changed please list the new address below.

New Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Please note: All fields below must be filled out in order for claim to be approved.

### Claim Information

Name of Dependent: \_\_\_\_\_ Dependent Date of Birth: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Tax ID: \_\_\_\_\_

Service Start Date\*: \_\_\_\_\_ Service End Date\*: \_\_\_\_\_

Claim Amount: \$ \_\_\_\_\_

Provider Signature (if you are unable to obtain a receipt): \_\_\_\_\_

Name of Dependent: \_\_\_\_\_ Dependent Date of Birth: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Tax ID: \_\_\_\_\_

Service Start Date: \_\_\_\_\_ Service End Date: \_\_\_\_\_

Claim Amount: \$ \_\_\_\_\_

Provider Signature (if you are unable to obtain a receipt): \_\_\_\_\_

### Employee Certification

- By signing this form, I agree to have my DCA account reduced by the amount requested.
- This claim for reimbursement is only for eligible expenses incurred by eligible plan participants during the plan year. Please refer to your SPD and Plan Document for information on eligible expenses.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- \*I understand and agree that I am obligated to inform Flexfacts in writing if the amount charged for the dependent care services change, the service is terminated, or if there is any reason the expenses are not incurred.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_