MyTru Advantage | Supported by Employee Benefits Corporation

# Vision Reimbursement Claim Form Instructions

You may submit a manual claim for reimbursement using this form if you have not received your Benefits Card or if your merchant was unable to process your Benefits Card payment at the time of purchase. Please submit one form per member.

To request reimbursement for eligible expenses, read these instructions thoroughly, complete the form on the next page, and return it by mail. To be processed, your claim must be received within 90 days after the plan year in which you received the eligible service or purchased the eligible product.

1. **Member Information**
   - Complete this section in full
   - Please be sure to include your MyTruAdvantage member ID; this is required to process your claim

2. **Expense Information**
   - Please complete one line for each receipt you are submitting for reimbursement
   - Submit additional forms if you have more than three receipts to submit

3. **Direct Deposit**
   - Complete this section in full. If you have already submitted your banking information with a prior MyTruCard claim, you do not need to do so again

4. **Required Documentation**
   - Your eligible expenses require an itemized receipt that includes/displays the following.
     - Name of provider or retailer
     - Date(s) of service
     - Service description or list of purchased items
     - Expense amount
     - Note: Credit card receipts without the above information are not adequate documentation

5. **Submit Your Claim**
   - Retain original copies for your records. Mail the completed form and documentation to:

     Employee Benefits Corporation
     PO Box 44347
     Madison, WI 53744-4347

**For more details about eligible and excluded expenses, refer to your current Evidence of Coverage by visiting mytruadvantage.com**

Questions? Call 844-425-4280 (TTY: 711)

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# Vision Reimbursement Claim Form

## Member Information

Last Name _____ First Name _____

Phone Number _____ Member ID | | | | | | | | | | | |

Reason for Manual Claim Reimbursement (Select one):
☐ I have not received my Benefits Card.
☐ Merchant was unable to process my Benefits Card payment at the time of purchase.

## Expense Information (Submit additional forms if you have more than three receipts.)

| Date of Service | Provider or Retailer Name | Claim Amount |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |

## Direct Deposit (Skip this step if you already provided bank account information using this form.)

| Bank Name | Account # | 9-digit Routing # | Account Type |
|---|---|---|---|
| | | | ☐Checking<br>☐Savings |

☐ I do not have direct deposit. Please mail me a check, which takes longer than direct deposit.

## Important Certifications Regarding This Claim

By submitting this form, I understand, agree with, and certify all of the following statements: (1.) Everything I entered on this form is complete and true. (2.) I must submit only eligible expenses, as defined by my plan, for reimbursement. These expenses have not been, nor will be, reimbursed by any other benefit plan. (3.) Employee Benefits Corporation (EBC), a partner of MyTruAdvantage, may obtain and use "protected health information" regarding coverage or benefits under the plan and disclose it to an insurer or other provider of services related to the plan. Any such use or disclosure will be only for purposes of the plan and only for as long as EBC is providing services to the plan. (4.) If I have included direct deposit information above, EBC is hereby authorized to send reimbursements (and appropriate adjusting entries) for this claim and future claims electronically or by any other commercially accepted method to my designated account at the financial institution above. This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it. EBC is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I must notify EBC immediately of any changes to my direct deposit information.

**Mail this form and the required documentation to:**
**Employee Benefits Corporation, PO Box 44347, Madison, WI 53744-4347**



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