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 > Participant Login > Register
2. Set up your username and password
3. Registration ID: choose 'Employer ID' and enter GBSMELBOE
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
7. **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

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

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.

FLEXFACTS
a company of grant benefit solutions

Please send this form along with all applicable receipts to:

1200 River Avenue, Suite 10E, 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:

1200 River Avenue, Suite 10E, 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: _____