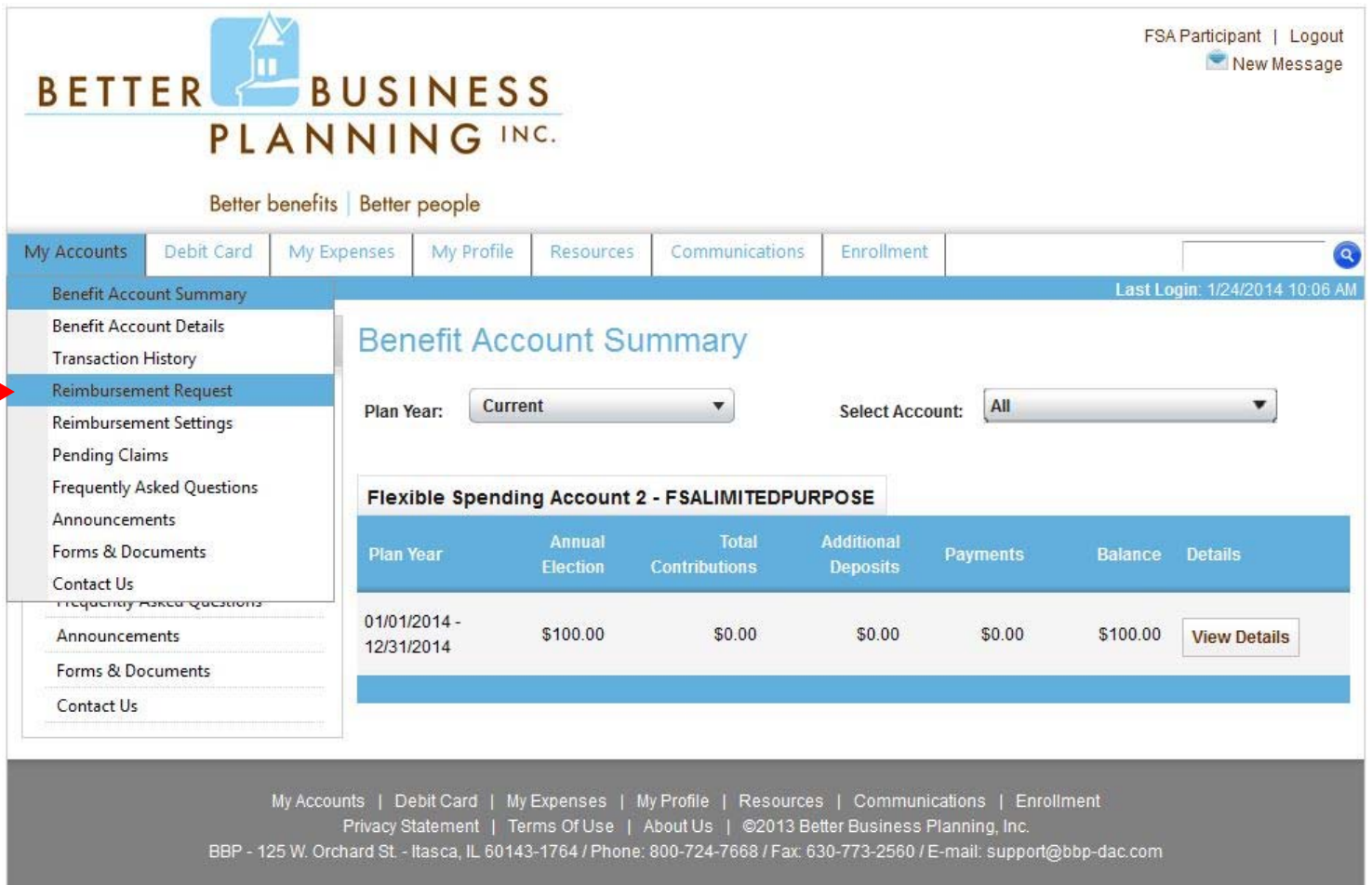


## Participant Portal Claim Entry Instructions

To enter manual claims, participants must take the following steps in the Participant Portal:

1. Click the Request Reimbursement link on the left hand menu to open the Request Reimbursement page.



The screenshot shows the participant portal interface for Better Business Planning Inc. The top navigation bar includes 'My Accounts', 'Debit Card', 'My Expenses', 'My Profile', 'Resources', 'Communications', and 'Enrollment'. A search bar is located on the right. The main content area displays the 'Benefit Account Summary' for a 'Flexible Spending Account 2 - FSALIMITEDPURPOSE'. The 'Reimbursement Request' menu item is highlighted with a red arrow.

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FSA Participant | Logout  
New Message

My Accounts | Debit Card | My Expenses | My Profile | Resources | Communications | Enrollment

Benefit Account Summary  
Benefit Account Details  
Transaction History  
**Reimbursement Request**  
Reimbursement Settings  
Pending Claims  
Frequently Asked Questions  
Announcements  
Forms & Documents  
Contact Us

Last Login: 1/24/2014 10:06 AM

### Benefit Account Summary

Plan Year:  Select Account:

**Flexible Spending Account 2 - FSALIMITEDPURPOSE**

Plan Year	Annual Election	Total Contributions	Additional Deposits	Payments	Balance	Details
01/01/2014 - 12/31/2014	\$100.00	\$0.00	\$0.00	\$0.00	\$100.00	<a href="#">View Details</a>

My Accounts | Debit Card | My Expenses | My Profile | Resources | Communications | Enrollment  
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BBP - 125 W. Orchard St. - Itasca, IL 60143-1764 / Phone: 800-724-7668 / Fax: 630-773-2560 / E-mail: support@bbp-dac.com

## Participant Portal Claim Entry Instructions

2. Click the “Add New” button to open the Add/Edit Claim page.

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My Accounts | Debit Card | My Expenses | My Profile | Resources | Communications | Enrollment | Last Login: 1/24/2014 10:06 AM

### Reimbursement Request

**Navigation**

- Benefit Account Summary
- Benefit Account Details
- Transaction History
- Reimbursement Request**
- Reimbursement Settings
- Pending Claims
- Frequently Asked Questions
- Announcements
- Forms & Documents
- Contact Us

**IMPORTANT – All claims need to be entered separately. For example, if you have 10 prescriptions you need to complete this form 10 times for each prescription. Also, if you have more than one account for reimbursement you must submit claims under both accounts based on the reimbursement formula for each account. All claims must be submitted with documentation that verifies the following: (1) Name of Patient, (2) Name of Provider, (3) Expense Incurred, (4) Date of Incurred Expense, and not date claim is paid, and, (5) amount of the expense. If the request is for an over-the-counter drug, you must have a doctor's note on file and indicate the name of the drug.**

**New Claims**

Start Date	End Date	Amount	Claimant	Provider	Receipt
<input type="button" value="Add New"/>					

**Certification:**

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's Plan. I, the undersigned, certify that a federally recognized dependent or I incurred these expenses and the expenses are eligible under federal law. **I fully understand that I alone am responsible for the sufficiency, accuracy, and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state, and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses.**

Please note: after submitting your claim(s) no edits are allowed.

## Participant Portal Claim Entry Instructions

3. Enter the following fields: Service Start Date, Claim Amount, Claimant, Reimbursement Method, Provider Name and Account Type (Optional fields: Service End Date, Pay Provider and Notes).
4. Click the Browse button to upload a receipt file.
5. Click OK

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New Message

My Accounts | Debit Card | My Expenses | My Profile | Resources | Communications | Enrollment

Last Login: 1/24/2014 10:06 AM

### Reimbursement Request

#### Add/Edit Claim

Please complete the claim form and upload your supporting documentation to process your claim. **REMEMBER – to complete one claim form per eligible item per account.** Failure to submit supporting documentation will result in your claim not being processed. If you fax your receipts to 630-773-2560 or e-mail to [support@bbp-dac.com](mailto:support@bbp-dac.com) please make sure to reference that you already completed the online claim form.

**Service Dates:** Start Date\* 1/1/2014 End Date

**Claim Amount \*:** \$ 0.01

**Pay Provider?**  Yes  No

**Claimant \*:** Participant, FSA

**Reimbursement Method\*:** Check

**Provider:** ABC Pharmacy

**Account Type\*:** FS2: FSALIMITEDPURPOSE(1/1/2014 to 12/31/2014 Ext. 3/1

**Receipt File:** ABC Rx Claim - \$0.01 - 01011

**Notes:**

\* = required

## Participant Portal Claim Entry Instructions

6. Enter any additional claims by clicking the Add New button.
7. Check the certification check box.
8. Click the Submit button. **Please Note:** If you leave the Participant Portal without clicking the Submit button, all claim information will be lost.

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FSA Participant | Logout  
New Message

My Accounts | Debit Card | My Expenses | My Profile | Resources | Communications | Enrollment

Last Login: 1/24/2014 10:06 AM

### Reimbursement Request

**IMPORTANT** – All claims need to be entered separately. For example, if you have 10 prescriptions you need to complete this form 10 times for each prescription. Also, if you have more than one account for reimbursement you must submit claims under both accounts based on the reimbursement formula for each account. All claims must be submitted with documentation that verifies the following: (1) Name of Patient, (2) Name of Provider, (3) Expense Incurred, (4) Date of Incurred Expense, and not date claim is paid, and, (5) amount of the expense. If the request is for an over-the-counter drug, you must have a doctor's note on file and indicate the name of the drug.

**New Claims**

Start Date	End Date	Amount	Claimant	Provider	Receipt
1/1/2014	1/1/2014	\$0.01	Participant, FSA	ABC Pharmacy	Edit

**Add New**

**Certification:**  
 I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's Plan. I, the undersigned, certify that a federally recognized dependent or I incurred these expenses and the expenses are eligible under federal law. **I fully understand that I alone am responsible for the sufficiency, accuracy, and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state, and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses.**

Please note: after submitting your claim(s) no edits are allowed.

**Submit** **Clear**