FLEXIBLE BENEFIT CLAIMS

CONTACT INFORMATION
Benefits Department

Phone: (925) 956-0514

Fax: (844) 859-7309

Email: benefits@pensiondynamics.com

Address: 2300 Contra Costa Blvd., Suite 400
Pleasant Hill, CA 94523

Website: www.pensiondynamics.com

Customer Service

The best way to check your claim status is to log into your account online at www.pensiondynamics.com. If you have not yet registered for an account, please contact Pension Dynamics Company LLC. The website is available 24/7 and is a great resource once you have registered.

Customer Service is available at (925) 956-0514 from 9 AM - 5 PM PST, Monday - Friday. You can also email us at benefits@pensiondynamics.com. Please include your name and your employer name on any correspondence sent to us but do not include confidential information such as your Social Security Number.

Important information before you begin

Tips for Completing the Claim Form

- Fill out each section completely. Incomplete forms will not be able to be processed.
- Type or write legibly and don't forget to sign your form. The employee who is participating in the plan is required to sign the form, either live with ink or as an electronic signature using a time-stamp (example: Adobe - Sign and Certify).
- If insurance is paying ANY portion of the services that you are requesting reimbursement for, please check YES. If you do not have insurance or if this item is not covered by your insurance, please check NO.

Things to Include with your Claim Form

- All Health Care substantiation must include:
  - Name of patient (you, your spouse or tax dependent) incurring the expense
  - Date the service provided or the item was purchased
  - Service Provider or Merchant Name
  - Description of Service/Purchase
  - Amount of Service/Purchase
  - If insurance is paying any portion, the statement must clearly show the finalized payment/write off amount
- All Dependent Daycare substantiation must include the following:
  - Dates of care provided *(not when billed/paid for)*
  - Description of Service
  - Dependent's Name
  - Care Provider's Name
  - Provider's Tax ID or SSN
  - Amount of Claim

If your provider does not give receipts Pension Dynamics can accept the provider's signature on the completed claim form as proof of your expense.

- Canceled checks, credit card receipts, and statements including "Previous Balance", "Balance Forward, or "Paid on Account" are NOT acceptable as they do not contain all of the required information.
- Handwritten statements must be on provider's letterhead or have a provider stamp containing their information.

Reminders for Submitting your Claim Form:

- Retain the original of all requests including the substantiation, sending us a **copy** of the documents only. Pension Dynamics is not responsible for providing copies.
- Please allow 2 business days for your claim to be processed. Payments are not able to be issued until after services have been incurred in full.
- If your claim is denied, you will receive a message online explaining why the claim could not be processed. If we need further information, the denial letter will state what you can do in order to have your claim re-processed within 180 days.
- Do **NOT** combine your claim with your co-workers' claims. It will not be processed.
- To submit, complete the Claim Form and attach all substantiation. You may upload the documents to secure.pensiondynamics.com or you can download our mobile application. This can be found by searching "Pension Dynamics WealthCare" in your app store.
- You may also Fax your Claim in it's entirety to (844) 859-7309 with a cover page.
- You may also mail a **copy** of your Claim in it's entirety to: Pension Dynamics Company LLC, Attn: Benefits Department, 2300 Contra Costa Blvd., Suite 400, Pleasant Hill, CA 94523-3987.

FLEXIBLE BENEFIT REIMBURSEMENT

FAILURE TO COMPLETE THIS FORM IN FULL MAY DELAY PAYMENT

Please consult your Employee Handbook or contact your Plan Service Provider to be sure your expense is eligible for reimbursement.

Plan Name: _____

Example "ABC Company Flexible Benefit Plan" If you are unsure about your Plan Name please contact your human resources or benefits department.

SECTION 1. EMPLOYEE INFORMATION

Name _____ Last Four Digits of SSN _____

Personal E-mail Address _____ Daytime Phone Number _____ Evening Phone Number _____

SECTION 2. HEALTH CARE CLAIMS *(if you are enrolled in a Limited FSA, eligible expenses are limited to dental and vision care)*

- Attach copy of Explanation of Benefits (EOBs) for deductible and coinsurance reimbursement requests.
- Attach **itemized bills** for expenses not covered by medical/dental/vision insurance. Itemized bills **must include** the date(s) of service, patient's name, provider's name, services provided, and amount of expense. Dual Purpose items must include information proving medical need.
- Please contact Pension Dynamics for information on how to submit Orthodontia claims.
- **Balance Forward Statements, Canceled Checks And Credit Card Receipts Are Not Acceptable.**

Provider / Vendor	Name of dependent who incurred the expense	Date(s) of Service	Insurance Coverage Yes	Insurance Coverage No	Requested Amount	Paid for with Benefits Card
			☐	☐		☐
			☐	☐		☐
			☐	☐		☐
			☐	☐		☐

If you need additional space to list expenses, please use another form. Total: _____

SECTION 3. DEPENDENT DAYCARE CLAIMS

Proof of expense **must include** dates of service, description of services, provider's name, amount of expense and provider's tax identification number (T.I.N) or Social Security Number. If no receipt is available, complete the claim form and have your provider sign where indicated. Handwritten receipts must include the provider's stamp or be on their custom letterhead.

Provider / Vendor	Name of dependent who incurred the expense	Date(s) of Service	Provider's SSN / TIN	Requested Amount

Total: _____

_____

Provider's Signature

SECTION 4. EMPLOYEE AUTHORIZATION

I certify the above expenses qualify for reimbursement under the terms of the Flexible Benefit Plan. I specifically state that the expenses listed have been incurred for the benefit of me and/or my eligible dependents. I have attached acceptable proof of expense to this form. I certify that the above is correct and complete and that all out-of-pocket expenses reimbursed to me under this program will not be deducted on my, or my spouse's, personal tax return or be reimbursed to me or my dependents by any other means.

_____ _____

Employee Signature Date

Attach proof and submit electronically: **https://secure.pensiondynamics.com/** or Fax: (844) 859-7309