

Number of pages faxed

WageWorks, formerly Creative Benefits  
 PO Box 1928, Vista, CA 92085-1928  
 FAX: Toll free (888) 295-5757 or (760) 758-4610  
 EMAIL: [claims.vista@wageworks.com](mailto:claims.vista@wageworks.com)  
 PHONE: Toll free (888) 295-5656

Claim forms and supporting documentation received prior to 2:00 p.m. Pacific Time, are processed the same day.

## Alternate Premium Claim Form

### SECTION A - EMPLOYEE INFORMATION

Name \_\_\_\_\_  
(Print or type: Last, First, Middle Initial)

Mailing Address \_\_\_\_\_

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

Daytime Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Email Address \_\_\_\_\_

*If you have an address change, be sure to update your records with your employer.*

Is this a new address? (check one)  YES  NO

Social Security # \_\_\_\_\_  
 or your Participant ID # \_\_\_\_\_  
as assigned by WageWorks, formerly Creative Benefits

Employer \_\_\_\_\_

Please send photocopies of forms and documents. Keep originals for your records, as claim and supporting documentation become part of this claim record and cannot be returned to you.

- The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, credit card receipts or statements are not acceptable documentation of expenses.
- Receipt of faxed claims cannot be verified due to our large volume. Please call the automated system at (888) 295-5656 after 5p.m. Pacific Time or go online to [www.creativebenefits.com](http://www.creativebenefits.com) to determine if your claim has been received and entered.

**SECTION B - EXPENSES TO BE SUBMITTED** Attach a **copy of the insurance bill** supporting listed item of expense. Include only expenses incurred in the same plan year.

name of insured	period covered (from - to) <small>Format date: mm/dd/yy</small>		insurance company	type of insurance	amount of expense
					\$
					\$
					\$
					\$
					\$
					\$
					\$

Total amount to be reimbursed \$ \_\_\_\_\_

**SIGN AND DATE  
 FORM EACH TIME**



I certify this claim in accordance with Section C - Employee Certification. Unsigned claims will automatically be denied.

PARTICIPANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### SECTION C - EMPLOYEE CERTIFICATION

I certify that:

- The Alternate Premium Account will not reimburse on individual Life Insurance policies.
- No reimbursement is permitted for premiums for insurance sponsored by another company or any other plan.
- I cannot claim these same incurred expenses for an income tax deduction. All of these expenses qualify as eligible expenses in accordance with the Plan and IRS regulations.
- By providing my email address, I am requesting all communications regarding my account be sent to me via email.