



**CITY OF WEST ALLIS
MARCH 1, 2016 – FEBRUARY 28, 2017
FLEXIBLE BENEFITS PLAN**

RETURN THIS FORM ONLY IF YOU ARE ELECTING TO PARTICIPATE IN DEPENDENT CARE AND/OR MEDICAL REIMBURSEMENT IN CONJUNCTION WITH THE PPO PLAN.

I. GENERAL INFORMATION

EMPLOYEE # _____

EMPLOYEE NAME: _____

MAILING ADDRESS: _____
(STREET)

(CITY) (STATE) (ZIP)

PHONE NUMBER: _____ (____) _____

SOCIAL SECURITY #: _____

II. FLEXIBLE SPENDING ACCOUNT- RETURN THIS FORM BY 5:00 P.M. WEDNESDAY, FEBRUARY 10, 2016.

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year will be forfeited. Expenses/claims must be incurred during the Plan Year in order to be eligible for reimbursement.

_____ I hereby elect to participate in the Flexible Spending Accounts as indicated below. **(NOTE: If you are enrolled in a High Deductible Health Plan, you ARE NOT eligible to participate in a Medical FSA; however you may still be eligible to participate in a Dependent Care FSA.)**

SPENDING ACCOUNTS – As a participant I hereby elect to participate in the Flexible Benefits Plan and therefore authorize the City of West Allis to reduce my wages on a **pre-tax** basis during each payroll period in the following amount. I understand this election must be re-authorized each year.

	PER PAY PERIOD		# PAY PERIODS		ANNUAL ELECTION
MEDICAL REIMBURSEMENT	\$ _____	X	_____	=	\$ _____

(A minimum deduction of \$300.04 per year is required; maximum deduction is \$2549.82)

DEPENDENT CARE (Day care expenses incurred during employment hours)	\$ _____	X	_____	=	\$ _____ (Max \$4,999.80)
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My pay schedule is bi-weekly.

III. AUTHORIZATION AND ACKNOWLEDGMENT

I understand I cannot revoke or change this election during the Plan Year unless there is a qualifying "Status Change" even that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

DATE _____

EMPLOYEE SIGNATURE _____

**RETURN this ENROLLMENT FORM to the FINANCE DEPARTMENT
Questions? Contact LAURELL KOHLER (x8246) or MELISSA WEISNICH (x8261)**

Direct Deposit Authorization

Fax to: **608 831 4790**
 Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
 Phone support: **800 346 2126**, 608 831 8445, M - F 8:00 - 5:00 Central
 E-mail support: **participantservices@ebcflex.com**

To enroll in Direct Deposit, please read the **Depositor Certification** and **Conditions of Participation** below. Be sure to sign and date the form.

Authorization New Direct Deposit Authorization Change Direct Deposit Authorization Cancel Direct Deposit Authorization

Account Holder Information **Last 4 Digits of Social Security or Identification Number**
(Required)

Last Name Suffix First Name MI

E-mail Address (we do not share your e-mail address) Employer

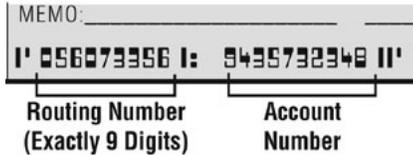
Home Phone Number (000-000-0000) Work Phone Number (000-000-0000)

Financial Institution Information

Financial Institution Branch

City State

Account Type: Checking Savings



Account Number (from check)

Routing Number (exactly 9 digits from check) *In most cases, the routing number precedes the account number. If in doubt, contact your financial institution.*

Depositor Certification

I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation 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. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). 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.

Account Holder Signature (Required) _____ Date (mm-dd-yyyy)

Conditions of Participation

Participants in the BESTflex Plan and EBC HRA have the option to have their authorized reimbursements deposited directly into their personal checking or savings account. It is an optional convenience called Direct Deposit. If you have any questions regarding your electronic transfers, call Participant Services at 800 346 2126 or 608 831 8445.

- If you decide to enroll in Direct Deposit, you must complete this authorization form.
- If you are enrolled in both the BESTflex Plan and EBC HRA, both of your accounts will be updated with this Direct Deposit information.
- The agreement represented by this authorization will remain in effect from one plan year to the next. To cancel it, you must complete a new Direct Deposit Authorization Form as a cancel transaction.
- It is your responsibility to notify us immediately of any changes in your financial institution (i.e. change of account number, closure of account, etc.).

- To notify us of the change, use the Direct Deposit Authorization Form. Mark the "Change" box in the Type of Transaction entry above. We will process these changes immediately upon receipt of the form. Since changes of this type usually take four business days to complete, please plan accordingly.
- Your electronic transfer will be made directly into your account. If your financial institution cannot make this transfer within three business days of receipt, we will investigate, then issue and mail a reimbursement check to you. Until the electronic transfer problem is resolved, you will continue to receive reimbursement checks in the mail. Reinstatement of Direct Deposit will be determined on a case-by-case basis and you will be notified if it occurs.
- Your financial institution may also cancel this agreement. In such cases, you will receive reimbursement checks in the mail.

Employee Worksheet

Fax to: **608 831 4790**
 Mail to: **Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347**
 Phone support: **800 346 2126 | 608 831 8445**
 E-mail support: **participantservices@ebcflex.com**

This worksheet will help you estimate the expenses for you, your spouse, and eligible dependents. Transfer the Deduction Per Pay Period for Health and Dependent Care to the Enrollment Form.

Group Insurance Premiums

If you participate in your employer's insurance plan(s), your premiums are deducted from your pay pre-tax unless you notify your employer otherwise.

My BESTflex Plan Accounts

If you establish a Health Savings Account (HSA), you may only enroll in the Limited Health Care FSA, which can only reimburse you for eligible dental, vision and preventative expenses and the Dependent Care FSA.

My Plan Dates (Refer to "My Company Plan" Eligibility section)

My Effective Start Date (mm-dd-yyyy) _____ to _____
 My Plan Year Start (mm-yyyy) _____ My Plan Year End (mm-yyyy) _____ # Payroll Deductions _____

Examples of Eligible Health Care FSA Expenses:

DENTAL SERVICES

- \$ _____ Crowns/Bridges
- \$ _____ Dental X-Rays
- \$ _____ Dentures
- \$ _____ Exams/Teeth Cleanings
- \$ _____ Extractions
- \$ _____ Fillings
- \$ _____ Gum Treatments
- \$ _____ Oral Surgery
- \$ _____ Orthodontia/Braces

INSURANCE-RELATED ITEMS

- \$ _____ Copays
- \$ _____ Coinsurance
- \$ _____ Deductibles

LAB EXAMS / TESTS

- \$ _____ Blood Tests
- \$ _____ Cardiographs
- \$ _____ Diagnostic Fees
- \$ _____ Laboratory Fees
- \$ _____ Spinal Fluid Tests
- \$ _____ Urine/Stool Analyses
- \$ _____ X-Rays

MEDICATION

- \$ _____ Insulin
- \$ _____ Prescribed Birth Control
- \$ _____ Prescribed Vitamins*
- \$ _____ Prescription Drugs (including co-pays)*

OVER-THE-COUNTER MEDICINE

Important: Starting January 1, 2010, the following over-the-counter medicines can only be reimbursed by the BESTflex Plan with a doctor's prescription:

- \$ _____ Allergy Medicines
- \$ _____ Antihistamines
- \$ _____ Analgesics
- \$ _____ Antacids
- \$ _____ Anti-Diarrhea Medications
- \$ _____ Anti-Itch Medications
- \$ _____ Anti-Nausea Medications
- \$ _____ Aspirin
- \$ _____ Athletes Foot Creams and Powders
- \$ _____ Cold Sore Remedies
- \$ _____ Cough Drops
- \$ _____ Cough Syrups
- \$ _____ Decongestants

\$ _____ Subtotal

- \$ _____ Eye Drops
- \$ _____ Fever Reducers
- \$ _____ First Aid Cream (*Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatments*)
- \$ _____ Digestive Tract Relief Medications
- \$ _____ Flu and Cold Medications
- \$ _____ Hemorrhoidal Medications
- \$ _____ Laxatives
- \$ _____ Lice and Scabies Treatments
- \$ _____ Menstrual Cycle Products (*for pain and cramp relief*)
- \$ _____ Motion Sickness Pills
- \$ _____ Muscle / Joint Pain Relievers
- \$ _____ Nasal Sinus Sprays
- \$ _____ Nicotine Gum / Patches
- \$ _____ Pain Relievers
- \$ _____ Pedialyte
- \$ _____ Retin A (*non-cosmetic*)
- \$ _____ Rubbing Alcohol
- \$ _____ Sinus Medications
- \$ _____ Sleeping Aids
- \$ _____ Smoking Cessation Products
- \$ _____ Sore Throat Sprays
- \$ _____ Special Ointments / Cream for Sunburns
- \$ _____ Throat Lozenges
- \$ _____ Vapor Rubs
- \$ _____ Weight Loss Drugs (*only to treat a specific disease*)
- \$ _____ Yeast Infection Treatments

OTHER MEDICAL TREATMENTS/ PROCEDURES

- \$ _____ Acupuncture
- \$ _____ Alcoholism (*inpatient treatment*)
- \$ _____ Breast Pumps and Lactation Supplies
- \$ _____ Chiropractor Services
- \$ _____ Drug Addiction (*inpatient treatment*)
- \$ _____ Hearing Exams
- \$ _____ Hospital Services
- \$ _____ Infertility
- \$ _____ In-vitro Fertilization
- \$ _____ Norplant Insertion or Removal
- \$ _____ Orthopedic Shoes
- \$ _____ Patterning Exercises
- \$ _____ Physical Examination (*not employment related*)
- \$ _____ Physical Therapy

\$ _____ Subtotal

- \$ _____ Speech Therapy
- \$ _____ Sterilization
- \$ _____ Vaccinations and Immunizations
- \$ _____ Vasectomy and Vasectomy Reversals
- \$ _____ Well Baby Care

OTHER MEDICAL SUPPLIES/SERVICES

- \$ _____ Abdominal/Back Supports
- \$ _____ Ambulance Services
- \$ _____ Arch Supports/Orthotic Insoles (*requires doctor's prescription*)
- \$ _____ Contraceptives
- \$ _____ Counseling (*except for Marriage and Family*)
- \$ _____ Crutches
- \$ _____ Guide Dog (*and other animal aides*)
- \$ _____ Hearing Aids & Batteries
- \$ _____ Hospital Bed
- \$ _____ Insulin Supplies
- \$ _____ Learning Disability (*special school/teacher*)
- \$ _____ Lead Paint Removal (*if not capital expense and incurred for a poisoned child*)
- \$ _____ Medic Alert Bracelet or Necklace
- \$ _____ Medical Miles, Tolls, and Parking
- \$ _____ Orthopedic Shoes** (*cost above regular shoes*)
- \$ _____ Oxygen Equipment
- \$ _____ Pregnancy Tests
- \$ _____ Pre-Natal Vitamins
- \$ _____ Prosthesis
- \$ _____ Reading Glasses
- \$ _____ Splints/Casts
- \$ _____ Support Hose (*if medically necessary*)
- \$ _____ Syringes
- \$ _____ Transportation Expenses (*essential to medical care*)
- \$ _____ Wheelchair
- \$ _____ Wigs (*hair loss due to disease*)

VISION EXPENSES

- \$ _____ Contact Lenses
- \$ _____ Contact Lens Solution
- \$ _____ Eye Examinations
- \$ _____ Eyeglasses
- \$ _____ Laser Eye Surgeries
- \$ _____ Prescription Sunglasses
- \$ _____ Radial Keratotomy/LASIK

\$ _____ Subtotal

This list is not meant to be all inclusive. Other expenses not listed may also qualify. Please refer to Section 213 of the Internal Revenue Code or call our toll free customer service line 800 346 2126.

Some medically necessary items may be covered by the Health Care FSA if prescribed by a physician for a specific medical condition. The prescription should contain the specific medical condition and timeframe for treatment.

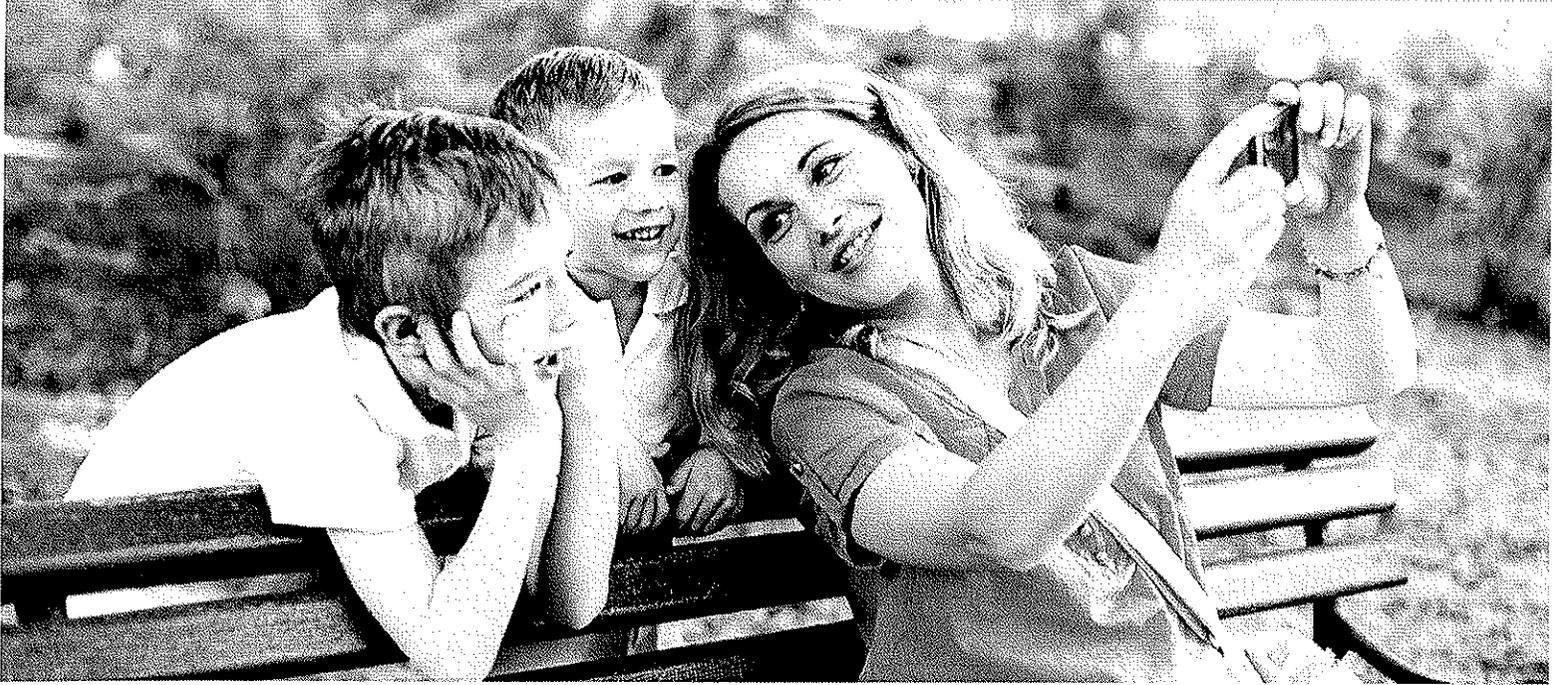
OVER-THE-COUNTER (OTC) MEDICINE

Important note about OTC medicine reimbursement: The Health Care FSA only reimburses your OTC medicine expenses if you have a doctor's prescription for them. Doctor's prescriptions must include the patient name, medication name, dosage, time frame for treatment and any other state law requirements. Only OTC drugs and medicines with a prescription and filled by the pharmacy will be eligible for reimbursement. Make sure you plan your annual Health Care FSA election accordingly.

*Excludes drugs imported from Canada and other countries

**Custom made shoes to treat or alleviate a specific medical condition. Included with the receipt should be a Letter of Medical Necessity from a physician. The excess cost above the normal cost of shoes is the eligible medical expense.

\$ _____
 Total Health or Limited Health FSA Election
 \$ _____
 Divided by #Payrolls = Deduction per Pay Period
 \$ _____
 Total Dependent Care FSA Election
 \$ _____
 Divided by #Payrolls = Deduction per Pay Period



Enroll in the BESTflexSM Plan and you'll pay less for eligible health care and daycare expenses.

Use **tax-free dollars** to pay for eligible health care and daycare expenses.

Tax-Free Dollars

The BESTflex Plan is an easy way for you to set aside a portion of your earnings, and use it to pay for insurance, health care and daycare expenses. The money you set aside in the BESTflex Plan is free from payroll taxes, so you save approximately 30 percent* in taxes for each dollar you contribute.

A Prescription for Savings

Whether your prescription medicine helps calm your allergies after snuggling with your cat, suppress heartburn after your favorite meal, breathe through your asthma – or something else entirely – the BESTflex Plan lets you pay less for it.

The plan saves you approximately 30 percent* in taxes on your eligible prescriptions and prescription co-payments, meaning a \$20 prescription expense amounts to about \$14.

Smile!

When you go out to socialize with your friends and meet new people, you trust in your bright smile to lend yourself confidence. It's no surprise, then, that you like to keep your smile in tip-top shape, despite how expensive it can be.

The BESTflex Plan helps you save approximately 30 percent* on your dental expenses, and keep your smile healthy and bright. A dental exam and cleaning might cost you \$100 – or more, depending on your provider. Using funds in the BESTflex Plan, you essentially pay around \$70. That's a savings that's likely to bring a smile to your face.

Daycare Relief

You know how the hundreds of dollars you spend on daycare each month can pinch your finances. The BESTflex Plan dulls the pinch. By saving you around 30 percent* on your daycare expenses, a week of care at \$150 is, in essence, closer to \$105.

Why pay more than you have to?

The BESTflex Plan makes it easy for you to set aside a portion of your earnings and use it to pay for certain insurance, medical and dependent care expenses. Because dollars you place in the BESTflex Plan are exempt from Federal, State and FICA taxes, you'll save approximately 30 percent* in taxes for each dollar you contribute.

Direct those tax savings toward your eligible BESTflex Plan expenses and a **\$20 prescription could cost \$14**. A week of daycare could cost \$70 instead of \$100 and your \$30 health insurance premium could cost you \$21.

The
BESTflex
Plan



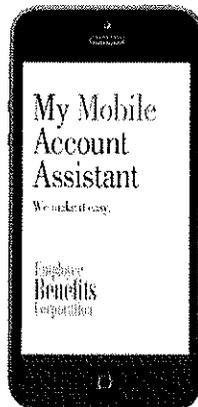
Our online videos explain where extra FSA dollars come from, the difference between FSA account types, and how to submit claims. **Watch them now!** Visit our website at www.ebcflex.com.

My Mobile Account Assistant

Smart, Simple,
Secure and Mobile!

- File a claim
- Attach receipts
- Check balances
- View payment history

Visit www.ebcflex.com to learn more.



How the BESTflex Plan Works

When you enroll in the BESTflex Plan, you set aside the portion of your pay you'll spend annually on eligible health and dependent care expenses. Throughout the year, these elections are deducted bit by bit from your paychecks and placed in flexible spending accounts (FSAs). The usual payroll taxes do not apply to your BESTflex Plan contributions, saving you from paying approximately 30 percent* in taxes on each dollar you contribute to the BESTflex Plan.

■ Just a Fraction of the Eligible Expenses

These savings can be applied to a variety of expenses. Prescription medicines, dental expenses, vision expenses – including contact lens solution, contact lenses and prescription eyeglasses – day care expenses and co-payments are just a few of the common expenses on which the BESTflex Plan helps you save money.

■ Enrollment in the BESTflex Plan

We help you set aside the right amount of money for eligible health care and dependent care expenses. Referencing your *Eligible Expenses List* and using the worksheets we've created, you'll arrive at a solid estimate of how much money you should contribute to the plan and help alleviate concerns about forfeiting any contributions.

■ Reimbursement From the BESTflex Plan

To get back the pre-tax money that's deducted from your pay and deposited in your FSA(s), simply submit a *Claim Form*, along with documentation, such as an itemized receipt, for the eligible expense. We quickly process your form and mail you a reimbursement check or deposit the payment into your bank account.

■ Filing Claims

We make filing claims easy and we offer three options: **Mobile, Online** or via a paper **Claim Form**

My Mobile Account Assistant lets you file a claim and scan and submit a receipt – at the pharmacy, your provider or anywhere you have access to a 3G or wireless internet connection. Filing a claim for any eligible health care or dependent care expense doesn't get any easier than this. Complete a few lines on a simple form, upload your receipt using your phone's camera and tap "Submit." My Mobile Account Assistant makes filing claims smart, simple, secure and mobile!

■ Participant Support

If you have questions or need information regarding your account, you can call our in-house Participant Services team at **800 346 2126** for one-on-one support, or access our convenient Telephone Account Assistant, which provides you with basic account details. We are also available via email at participantservices@ebcflex.com.

Download information regarding The BESTflex Plan and your FSAs by activating then logging in to My Account Assistant at www.ebcflex.com.

*These tax examples are broad approximations of tax liability. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all BESTflex Plan matters.

Substantiating and Submitting Flexible Spending Account Claims for Quick, Easy Reimbursement.

IRS regulations require that you substantiate, using four key details, every expense you submit for reimbursement from your BESTflexSM Plan Flexible Spending Accounts (FSAs).

How Do I Properly Substantiate Flexible Spending Account (FSA) Expenses?

Both the Health Care FSA and Dependent Care FSA, in accordance with IRS guidelines, require that certain information be included in the expense documentation.

For the Health Care FSA, receipts and expense documentation must include the following:

- A. Date(s) of service
- B. Type of expense (e.g., eye exam)
- C. Amount of the expense incurred
- D. Name of Service Provider

For the Dependent Care FSA, receipts and expense documentation must include:

- A. Date(s) of service
- B. Charges
- C. Name of Service Provider

Substantiating Claims For Your Health Care FSA:

- Certain procedures and items need a Letter of Medical Necessity from a physician as part of your reimbursement documentation; they must contain a specific diagnosis, state that the procedure or item is used to treat or cure the diagnosis, and indicate the duration of the expense
- Cosmetic procedures are not covered under the BESTflex Plan
- Orthodontia contracts must contain the treatment start date, fee schedule and duration of payments

Substantiating Claims For Your Dependent Care FSA:

- Services must be incurred BEFORE they can be reimbursed
- Separate documentation, which shows the name of the provider, dates of coverage and amounts, is required

How Do I Submit A Claim Form?

When you incur a medical or dependent care expense during the plan year, you send a Claim Form and expense documentation to Employee Benefits Corporation.

1. Complete a Claim Form and attach documentation, supporting invoices, receipts, Explanation of Benefits (EOB), etc.
2. Sign the form
3. Photocopy the form and documentation for your records

Submit The Form By U.S. Mail:

You may submit in one envelope as many forms with documentation as you like. Be sure the documentation is stapled to the Claim Form to which it applies or your claim may be excluded.

Submit The Form By Fax:

Submit only one form with documentation per fax transmission. Be sure the documentation is faxed with the Claim Form to which it applies or your claim may be excluded. It usually takes two business days to process faxed claims. Once they are processed, you can quickly and easily review the status of your claim on our website at www.ebcflex.com.

Submit The Form Online:

Submit claims and documentation using our online claim-filing tool. It's smart, simple and secure.

Do Not Submit A Form If Claims Are Submitted Electronically:

If your provider or carrier electronically submits claims to Employee Benefits Corporation, you should not submit a Claim Form for those expenses. Contact your Human Resources Department for more information.

The
BESTflexSM
Plan

Employee Benefits Corporation

Claim Form

Fax to: 608 831 4790
Mail to: Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347
Phone support: 800 346 2126, 608 831 8445, M - F 8:00 - 5:00 Central
E-mail support: participantservices@ebcflex.com

Account Holder Information
To ensure timely and accurate claims processing, please complete the entire form.

First Name: _____
Last Name: _____
Employer: _____
E-mail Address (we do not share your e-mail address): _____

Benefit Codes: Health Care FSA Limited Health Care FSA Dependent Care FSA Indv Billed Ins Premiums HRA

Benefit Code: _____
Enter one Benefit Code per claim line below.

Service Start Date (mm-dd-yyyy): _____
Service End Dates (mm-dd-yyyy): _____

Description of Service: _____
Provider: _____

Person Receiving Service (Required for HRA)
\$ _____
Claim Amount

Last 4 Digits of Social Security or Identification Number (Required): _____

Read This Information BEFORE You File For Reimbursement!

- **We cannot reimburse your expenses without your signature;** you must completely fill out, sign and date the Claim Form
- **Employee Benefits Corporation cannot reimburse you until expenses are actually incurred;** we cannot use estimates or pre-payment billings
- **Employee Benefits Corporation cannot accept** balance forward or previous balance statements
- **Double check your attached documentation** and make sure the information, such as date(s) of services, type of expense, amount, etc., is provided
- **Cancelled checks or credit card statements are not valid** documentation and Employee Benefits Corporation cannot accept them
- **When photocopying your documentation,** make sure the copies are clear and complete
- **If you are unsure whether an expense is reimbursable,** contact us before you incur the expense at 800 346 2126 or by email at participantservices@ebcflex.com

Old Plan Year

2-1/2 Month Grace

90-day Run-out

New Plan Year

How Do I Submit Year-End Claims?

Because your employer has a 2-1/2 month Grace Period in place, you can incur expenses for 2-1/2 months after the plan year ends. Claims submitted for expenses incurred during the 2-1/2 month Grace Period will first be paid using funds from your previous plan year. Once that money has been used, claims will be paid using funds from the current plan year, provided you chose to participate and funds are available.

To use the Grace Period for a claim that is greater than the amount remaining in your old account, the claim must draw from both the old and new accounts. The expense must be incurred during the 2-1/2 month Grace Period. Submit all your claims no later than the last day of the 90-day run-out.

We cannot reprocess or reorder your claims to pay out of a different year. It is your responsibility to submit claims against the correct plan years as described previously. You can look up your account information on our website. If your new plan year is listed, it is activated and ready for use. You can also call us before you submit your claim at **800 346 2126**. A Participant Services Representative will look up your account information and walk you through your claims submission process.

You have until the last day of the 90-day run-out to submit your claim. Claims submitted within this window will be applied to the plan year in which they were incurred. If you terminate during the plan year, you have only 90 days to submit claims after your termination date. The 2-1/2 month Grace Period will not apply.

Expenses incurred during your **Grace Period** are first claimed against any remaining funds from the previous plan year.

Exclusions: What Do I Do When A Claim Is Excluded?

If a claim is deemed invalid (excluded), you will receive an Exclusion Letter identifying the expense and the reason it was excluded. If you resubmit the claim, include the Exclusion Letter and any additional documentation or requested information within 180 days of receiving the Exclusion Letter. Additional information on resolving claims is available in the Summary Plan Description.

Remember: You can submit claims and documentation online. Log-in to My Account Assistant at www.ebcflex.com.

