

WealthCarePortal



Participant Guide to Accessing Benefits Online



Employers

Consultants



TIP: Bookmark This Page



Benefits Card
Information



Documents
& Forms



Eligible
Expenses



Tools &
Calculators



Video Library
Education & Training



WealthCare
Mobile



Benefit *Resources*,
Including Forms, Are Available
Before You Login

Please note that this portal has educational materials about a number of different benefit accounts. Remember, some of these accounts may not be available to you through your employer, or they may be administered by a TPA other than American Benefits Group, If you are unsure whether American Benefits Group administers any of these benefits for your company contact your HR office or call American Benefits Group customer support at 800-499-3539.



Benefits Card
Information



Documents
& Forms



Eligible
Expenses



Video Library
Education & Training



WealthCare
Mobile

Mobile App

Welcome to American Benefits Group



800-499-3539
support@amben.com

 SIGN IN  REGISTER

If You Are a Registered User
SIGN IN

If You Have Not Registered
For The Site - You Will Need
To Register





Note: You will need your Employer ID or ABG Benefits Card Number



To register with this site, you must have an **Employee ID** and a **Registration ID**, which is either your Employer's Employer ID or your Benefit Debit Card Number.

Register

STEP 1

STEP 2

STEP 3

STEP 4

 Username *

 Password *

Password Strength

 Confirm Password *

First Name *

Initial

Last Name *



Username must be between 9 and 15 characters long alphanumeric value



A valid **password** must contain between 8 and 16 characters.

A password must contain 3 of the following types of characters:


- AN UPPER CASE LETTER
- lower case letter
- Special Character (% , ! , @ , etc.)
- A number


A password cannot contain:

- The same character repeating 3 or more times
- The word "password"
- The username
- Spaces


Note: Username and Password Requirements



 Email *

 Employee ID *

Registration ID *

Employer ID 

Employer ID

Card Number

Note: Your Employee ID in most cases is your SSN



Employee ID was assigned by your Administrator and could be your Health Plan Member Number, Social Security Number, an ID provided by your Employer or an alternate ID created by your Administrator.

If you do not know your ID or were not provided an ID, please contact your Administrator.

Note: If you have an ABG Benefits Card you can use that number

I accept Terms of Use



NEXT



CANCEL



Register - Secure Authentication

STEP 1 > **STEP 2** > STEP 3 > STEP 4

Select Question 1 *

In which city did you get engaged?

Type your answer here

Select Question 2 *

In which city did your oldest sibling get married?

Type your answer here

Select Question 3 *

What was the first name of your first grade teacher?

Type your answer here

Select Question 4 *

What is your father's middle name?

Type your answer here



Please use the following list to choose four questions which are relevant to you and then enter answers to those questions. These questions may be asked during the sign on process to confirm that an authorized individual can access account information online.

Step 2:

Provide answers to challenge questions.

TIP: Store these answers in a safe place. You will be prompted to answer two questions to reset your password, or if you login on a non-registered computer.



NEXT



CANCEL



Step 3: Verify Email Address.

Register - Secure Authentication



First Name Y

Last Name Smith

 Confirm Email *



The email address entered is used for security encryption only. It is not used for solicitation purposes.

 NEXT

 CANCEL



Register - Secure Authentication



Your setup information has not yet been submitted. Please verify your information below before clicking **Submit**. If you need to make a change before submitting, click the appropriate **Edit Info** link

Step 4:
Review and Submit

Questions and Answers

Question 1

What was the TV series you liked most in the 1990s?
1960



EDIT INFO

Question 2

In which city did your oldest sibling get married?
1960

Question 3

What was the first name of your first grade teacher?
1960

Question 4

What is your father's middle name?
1960

Personal Information

First Name Y
Last Name Smith
Email ebonney@amben.com



EDIT INFO



Success

You have successfully completed the registration process



The next time you sign on to access your account information you will be asked to provide your **username** and **password**



To protect your personal information you may occasionally be required to complete additional authentication

✓ DONE

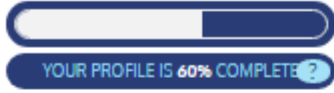


Alerts **17**

Hi, James Borden



James Borden



YOUR PROFILE IS **60% COMPLETE**?

Complete your profile and take advantage of all our capabilities.

MOBILE PHONE



Register your phone for real time alerts!

EMAIL



EBONNEY@AMBEN.COM

REIMBURSEMENT METHOD



DIRECT DEPOSIT

ALERTS



YOU HAVE OPTED INTO **6** ALERTS

Important: This is the main menu.

Want to Get Ahead of Your Health?

Don't Forfeit Your Funds. Join GoodCell.



Genetic Testing*



Health Screening*



Cell Storage



[Learn More](#)

*FSA/HSA eligible.



My Accounts - Click Down Arrows to View More

Plan years to show: Previous Current Future

Health Flexible Spending Account (01/01/2020-12/31/2020)



Available \$1,723.11 Spent \$976.89

Health Flexible Spending Account (01/01/2021-12/31/2021)



Available \$2,250.00 Spent \$500.00





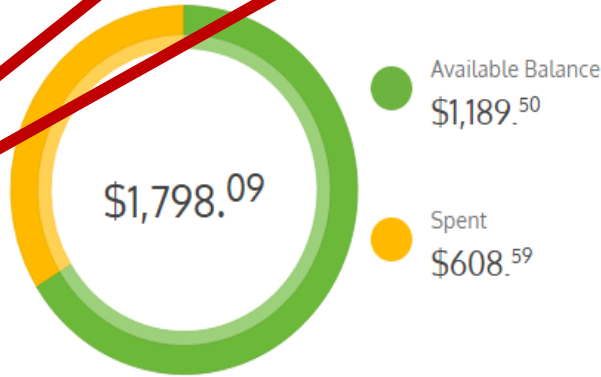
- Home
- My Account
- Benefit Account Summary**
- Communication Settings
- User Profile
- Contact Us
- Claims
- Resources
- Enrollment

Flexible Spending Account - MCM (01/01/2020-12/31/2020)

- VIEW DETAILS
- TRANSACTIONS
- SUBMIT CLAIM

Account Balance

Quick Action Links



Account Summary

Payroll Deposits YTD	\$1,798. ⁰⁹
Annual Allocation	\$1,798. ⁰⁹
- Spent	\$608. ⁵⁹
= Balance	\$1,189.⁵⁰

Deadlines

Plan Start	Jan 1, 2020
Plan End	Dec 31, 2020
Last Day for Spending	Mar 15, 2021
Last Day to Submit Claims	Mar 31, 2021

Scroll down to see all accounts





- Home
- My Account
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- Communication Settings**
- User Profile
- Contact Us
- Claims
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- Enrollment

Assigned Notifications

i You are opted-in to one or more mobile communications, but do not have a mobile number registered. You will not receive these communications unless you register a mobile number.

i The notifications below are available to you. Please define the delivery method for each notification you wish to receive. Please ensure you have an email address and/or registered mobile in order to receive these notifications.

 mobile  email  both

Account Balance Statement	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
This communication is sent on a Monthly basis.			
Card Mailed	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
This communication is sent when your card has been mailed.			
Direct Deposit Account Change	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
This communication is sent when your direct deposit account has been updated.			
Email Address Change	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
This communication is sent when your email address has been updated.			

Email Address

email@company.com  

Phone Registration Status

+ ADD NUMBER

Register Your Phone to Receive Account-based Text Messages



AMERICAN BENEFITS GROUP
WealthCarePortal

User Profile

Home Address
Street
City, State Zip Code

Phone
Email Address [edit](#) [delete](#)
email@company.com

Employer [edit](#)

SSN
XXX-XX-
Employee Status
Active

Checking

EDIT PROFILE

Home
My Account
Benefit Account Summary
Communication Settings
User Profile
Contact Us
Claims
Resources
Enrollment

[change picture](#)
James Borden
Date of Birth
June 6, 1960
Employee ID

Marital Status
None
Gender
Female

Family Members



Elizabeth Borden Spouse Or Common Law Spouse

Baby Borden Child

+ ADD FAMILY MEMBER


**Edit Profile,
Change Password,
Add or Edit Family Members**



<p>James Borden</p> <p>Date of Birth June 6, 1960</p> <p>Employee ID *****</p> <p>Marital Status Married</p> <p>Gender Male</p>	<p>Mailing Address Address City, State Zip Code</p> <p> Employer Demo Group</p> <p>SSN XXX-XX-</p> <p>Employee Status Active</p>	<p> edit</p> <p>Reimbursement Method Check</p>
--	--	--

Add Dependent Card

Family Members [+ ADD FAMILY MEMBER](#)

 Elizabeth Borden	Spouse Or Common Law Spouse
--	-----------------------------



Family Members

[+ ADD FAMILY MEMBER](#)

 Elizabeth Borden Spouse Or Common Law Spouse

Date of Birth Jun 6, 1956

SSN *****3786

Gender None


Phone

Employer Demo Group

Dependent ID *****23d1 

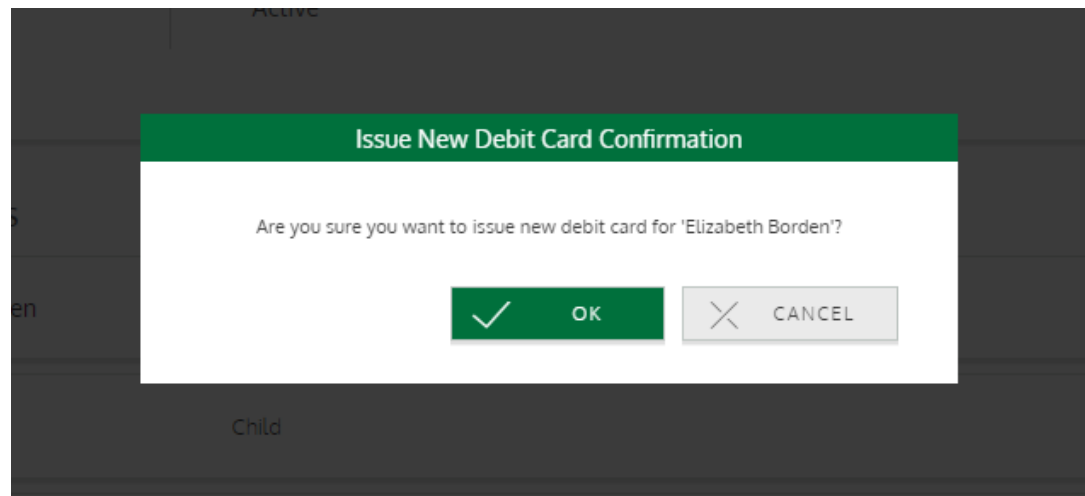
Home Address

50 Main St
Nowhere
CO, 76543
US

 EDIT DEPENDENT

 REMOVE DEPENDENT

[+ ISSUE DEBIT CARD](#)





- Home
- My Account
 - Benefit Account Summary
 - Communication Settings
 - User Profile**
 - Contact Us
- Claims
- Resources



Phone

Email Address [edit](#)
ebonney@amben.com



Home Address

1111 New Street
New Northampton
MA, 01060
US

Mailing Address

PO Box 3333
Northampton
MA, 01061-1209
US



EDIT PROFILE

Edit Profile or
Change Password



Employer

Demo Group

SSN
XXX-XX-3786

Employee Status
Active

Add a Family Member

Reimbursement Method

Direct Deposit

Account Number
*****8864

Routing Number
*****0281

Checking

+ ADD FAMILY MEMBER



Choose "Use your primary address"

Add Family Member

First Name * Last Name *

Initial

General Info Use your primary address

Relationship

Date of Birth *

SSN *

Gender *

Phone

Full-time student



AMERICAN BENEFITS GROUP
WealthCarePortal

Add a Claim

- Home
- My Account
- Claims
- Add a Claim**
- Claim Activity
- Transaction History
- Reimbursement Settings
- Add Expense
- Resources

Add a Claim

CLAIM DETAILS

DOCUMENTATION

CONFIRM SUBMISSION



Claim Form Instructions

Service Date(s): When you had the service or purchased an item. If you have multiple services over a period of time from the same provider you can enter a date range.

Claimant: Primary account holder's name.

Service Type: Choose service type from drop-down.

Claim Amount: Original expense amount.



Provider Name: Name of service provider such as the name of a doctor's office or pharmacy.

Account Number: Not Needed - we do not pay Providers directly

Comments: Use for additional information.

Attach Claim Receipt: Upload receipts/statements. If receipt is unavailable at time of submission, submit via the WealthCare Mobile App (learn more) or fax statements and/or EOBs to 877-723-0147.

If you have an HRA and are submitting Deductible, Copay or Coinsurance expenses, please provide an Explanation of Benefits (EOB) from your insurance carrier. [Sample EOB](#).

Choose the most appropriate Service Type, from the drop-down menu

Enter Service Dates – Not the date that you paid for the expense.

* - Required Field



Service Type *

-- Select One --



Service Start Date *

select date



Service End Date

select date



Claimant


Borden, James




Enter the
Provider Name


 Claim Amount *

\$ 0.00

 Provider Name

 Account Number

 Comments

 CANCEL

 NEXT



CLAIM DETAILS

DOCUMENTATION

CONFIRMATION



Please Choose a Validation Method to Continue



Attach Claim Receipt

Take a photo of your receipt or attach an existing document now.



Validate Later

Submit the claim without a receipt now, knowing a receipt is required for claim approval.



CANCEL



Documentation must show:

Date of Service; Who Service Was For; Nature of Service; Service Provider and Amount

Credit card receipts are not acceptable.

For most HRA expenses an EOB from your insurance carrier is required.

The screenshot shows a web interface for uploading receipts. At the top left, there is a document icon with a dollar sign and the text "Upload Receipt". To the right is a text input field followed by a blue "BROWSE" button, which is pointed to by a red arrow from the text above. Below this is a large dashed rectangular area containing a receipt icon with a dollar sign and a plus sign, and the text "DRAG & DROP your receipts here". At the bottom of the interface are two buttons: a green "NEXT" button with a white checkmark icon, and a grey "CANCEL" button with a white 'X' icon.



CLAIM DETAILS


DOCUMENTATION

CONFIRM SUBMISSION

Claim Details


Amount: \$40.⁰⁰
Claimant: James Borden
Service Type: IN-Network Lab
Service Start Date: Feb 9, 2021
Service End Date: Feb 9, 2021
Comments: Copay
Provider: Quest

Certify and Submit.

 FSA_Employee_FAQ_carryover.pdf

I certify that the expenses for reimbursement indicated on this claim form were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Reimbursement Plan(s). I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

 CANCEL

 SUBMIT



Thank you!

Thank you for using our online claim entry feature. If you were unable to upload your receipt electronically please fax it along with a copy of your receipt to 877-723-0147. If you have direct deposit information on file you can expect to receive your reimbursement in approximately 7 days, for reimbursement by check you can expect to receive the check in approximately 10-12 days.

What do you want to do next?



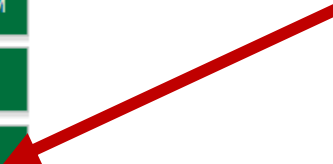
SUBMIT ANOTHER CLAIM



OPEN CLAIMS LIST



PRINT A CLAIM FORM





Claim Receipt Submittal Form

- Participant:** James Borden
Do not mark this barcode. It doesn't contain any personal information, and is necessary to speed up processing.
- Date Submitted:** 1/2/2019 6:00:00 AM
This barcode is unique and this form should not be re-used.
- Total Requested:** \$900.00



###1T00916#####19670

You can fax this letter with your documentation to:
877-723-0147

Claims Submitted With Receipts:

Start Date	End Date	Amount	Claimant	Provider
01/02/2019	01/02/2019	\$900.00	James Borden	MyEyeDoc

Instructions and Certifications

If you did not upload your receipt please print this page and fax it with your documentation to 877-723-0147.



Once submitted you can view under **Claims > Claims Activity**

Once paid status will change from Submitted to Approved



Alerts

- Home
- My Account
- Claims
 - Add a Claim
 - Claim Activity**
 - Transaction History
 - Reimbursement Settings
 - Add Expense
- Resources
- Smart Accounts

Claim Activity

2021 Plan All Status All SUBMIT CLAIM

Which activities do you want to see? Select here

Approved
 Pending
 Denied
 Action Required
 No Action
 Action(s)

[SEARCH FOR ACTIVITIES](#)

	Pending	Feb 9, 2021	\$40.00	Needs Receipt	ADD RECEIPT
	Pending	Feb 1, 2021	\$30.00	Submitted – Under Review	
	Approved	Jan 1, 2021	\$200.00	Approved	Feb 23, 2021 Dependent Care Account



REIMBURSEMENT SETTINGS

For faster reimbursements provide your Direct Deposit information.

Choose Claims > Reimbursement Settings

The screenshot shows the 'Reimbursement Preference' page in the WealthCare Portal. On the left is a navigation menu with options: Home, My Account, Claims, Add a Claim, Claim Activity, Transaction History, Reimbursement Settings (highlighted), Add Expense, Resources, and Smart Accounts. The main content area is titled 'Reimbursement Preference' and shows a 'Reimbursement Method' section with two radio button options: 'Check' (which is currently selected) and 'Direct Deposit'. A red arrow points to the 'Direct Deposit' radio button. Below the options are 'CANCEL' and 'SAVE' buttons.

TIP: Enter Direct Deposit before entering claim



Reimbursement Method

Check
 Direct Deposit

Bank Name *
 Account *
 Re-enter Account *
 Account Routing *
 Re-enter Routing *
 Bank Account Type

By providing my bank account and routing numbers, I agree to allow my administrator to direct deposit plan reimbursements into my accounts. I understand that I can change this directive at any time.

Check example

Name _____ Date _____
 Address _____
 Pay to the order of: _____
 Your bank
 1 2 3 3 2 1 1 2 3 1 : 2 3 4 5 1 1 1 2 3 4 5 6 7 8 9 1 2 3
 Routing Number Check # Account Number

i Please note: The order of Routing, Account and Check numbers will vary from financial institution to financial institutions and will not necessarily be in the same order as shown above.

TIP: Enter Direct Deposit before entering claim



- ☰
- AMERICAN BENEFITS GROUP
WealthCarePortal
- Forms & Documents
- Home
- My Account
- Claims
- Resources
- Announcements
- Forms & Documents
- Plan Documents
- Commuter Resources
- DCA Resources
- FSA Resources
- FSA Learning Center
- Shop Exclusive Deals
- HSA Bank Disclosures
- Video Library
- Open Enrollment Guide
- Visit FSA Store
- Smart Accounts

Forms & Documents

Avida Bank HSA Forms

- [Account Closure Form](#)
- [Authorized User Form](#)
- [Beneficiary Form](#)
- [Contribution Form](#)
- [Contribution Correction Form](#)
- [Distribution Reversal Form](#)
- [IRS Publication 969](#)
- [IRS Form 8889](#)
- [Instructions for Form 8889](#)
- [Rollover Distribution Form](#)

Check Orders You can order checks anywhere you wish. Please note if you use the order link below you will receive 25 checks for \$8.00.

[Check Order \(Order a checkbook to associate with your HSA\)](#)

Transfer Form (Transfer Existing HSA Funds to Avidia Bank)
Depending on the existing custodian it could take up to 6 weeks before the Transfer Check is sent to Avidia Bank.

Flexible Spending Accounts

- [Flexible Spending Accounts & Commuter - Claim Form](#)
- [Flexible Spending Accounts - Claim Form](#)
- [Flexible Spending Accounts - Claim Form - Spanish](#)
- [Limited Purpose FSA - Claim Form](#)
- [Flexible Spending Accounts - Election Form](#)
- [Flexible Spending Accounts & LPP - Election Form - 2018](#)

Health Reimbursement Arrangement

- [Health Reimbursement Arrangement \(HRA\) - Claim Form](#)
- [Health Reimbursement Arrangement \(HRA\) - Enrollment Form](#)

Dependent Care

- [Dependent Information for Dependent Care](#)
- [Dependent Care Eligible Expense Table](#)
- [Receipt for Dependent Care Services](#)
- [Automatic Dependent Care Claim Form](#)
- [W10 Form to Request Dependent Care Provider's Tax ID](#)
- [Dependent Care Worksheet](#)
- [244I Dependent Care Expense Form](#)
- [244I Instructions](#)

Commuter Accounts

- [Commuter Transit & Parking - Flyer](#)
- [Commuter Parking - Claim Form](#)
- [Commuter Accounts - Enrollment Kit](#)
- [Commuter Transit and Parking Election/Change Form](#)
- [Commuter Parking Election/Change Form](#)
- [uberPOOL](#)
- [Lyft Line](#)
- [Frequently Asked Questions](#)



- Home
- My Account
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- Resources
- Announcements
- Forms & Documents
- Plan Documents
- Commuter Resources
- DCA Resources
- FSA Resources
- FSA Learning Center
- Shop Exclusive Deals
- HSA Bank Disclosures
- Video Library
- Open Enrollment Guide
- Visit FSA Store
- Smart Accounts

Dependent Care Account Tutorial



Frequently Asked Questions

Each of your benefits has its own resource page with videos, FAQs and other benefit specific information.

[Dependent care basics](#)
[Benefits](#)
[Eligible expenses](#)
[Contributions](#)
[Account access](#)

DEPENDENT CARE BASICS

How does a dependent care FSA work?

What is a dependent care FSA?
 A dependent care FSA is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work.



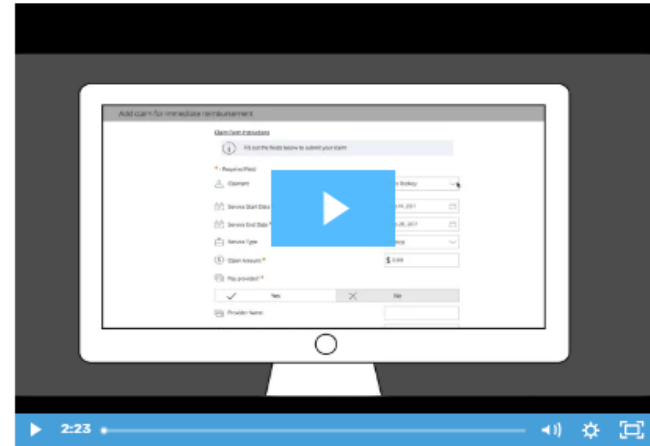
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Video Library



How Does My ABG Benefits Card Work?



How Do I File a Claim

