



Employee Benefit Management Services, Inc.

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FLEX AUTO-ORTHODONTIA REIMBURSEMENT

Form with fields: Employer Name, Employer Group Number, Employees Last Name, First Name, Employee's ID Number, Address, E-mail Address, Daytime Phone, Home Phone

Patient's Name

To enroll in the Automatic Orthodontia FSA (Flex) Reimbursement Program, please complete, sign, date and return this form. The Auto-Ortho program is not available until all Orthodontia Benefits are exhausted or if you are signed up for Auto-Flex. Auto-Ortho will be in effect for the earliest of the following: end of plan year, end of contracted payment terms, or in accordance of the installment start and ending dates listed below. If the contract lasts multiple plan years, please note that information specifically in the "from" and "to" dates listed below.

1) Total fee Remaining: \$ _____

2) Monthly installment payment: \$ _____

a) Will installment payments continue for the entire plan year? [] YES [] NO

If no, Please indicate the starting and ending date:

From _____ to _____

3) Amount you are requesting for reimbursement each month: \$ _____

Please provide a copy of the contract, a copy of the claim, and any other insurance payment consideration information

To the best of my knowledge and belief, my statements in this Automatic Orthodontia Reimbursement Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. This medical expense has not been reimbursed or is not reimbursable under any other health plan coverage and will not be claimed as an income tax deduction. I authorize my Flexible compensation account be reduced by the amount requested.

Employee Signature _____ Date _____

Please return this completed form to EBMS via fax to 877-236-9868 or via email to flex@ebms.com