

AUTOMATIC ORTHO REIMBURSEMENT

To enroll in the Automatic Orthodontia Flex Reimbursement Program, please complete, sign, and date this form.

Insured: _____ Group: _____

Insured's ID #: _____

Patient's Name: _____

PAYMENT INFORMATION

1) Total fee Remaining: \$ _____

2) Monthly installment payment: \$ _____

a) Will installment payments continue for the entire plan year? _____

Please indicate the starting and ending date:

From _____ to _____

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

PLEASE BE SURE TO ENCLOSE THE APPROPRIATE BILL(S) FROM THE ORTHODONTIST INDICATING ALL NECESSARY INFORMATION.

*** To the best of my knowledge and belief, my statements in the Request for Reimbursement 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's Signature _____

Date _____