

Change Reasons: Rehired Employee • Marriage • Legal Separation • Divorce • Dependent Change •
• Direct Deposit Change • Other Change •

Reason for Application: _____ Date of Event: _____

Employer Name: _____

Member ID: _____ **Phone #:** _____ - _____ - _____

Your Social Security Number or your unique ID Number assigned by your program sponsor.

Name: _____
Last First M.I.

Address: _____
Street Apt.

City State Zip

Email Address: _____

Member DOB: ____/____/____ Do you have Medicare? If yes, enter your Medicare #: ____-____-____
Date of Birth (MM/DD/YY)

Please list your HRA eligible dependents below.

Dependent 1: _____
Last First M.I. Gender Social Security Number Date of Birth (MM/DD/YY)

Dependent 2: _____
Last First M.I. Gender Social Security Number Date of Birth (MM/DD/YY)

Dependent 3: _____
Last First M.I. Gender Social Security Number Date of Birth (MM/DD/YY)

Elected Coverage Single Employee Plus One Family **Effective Date:** ____/____/____

AutoPay Yes, enroll me in AutoPay. Autopay automatically reimburses you for your out-of-pocket expenses processed by ODS. (See page 2 for more details.)

Direct Deposit will electronically deposit your reimbursement to your bank account.

Direct Deposit Yes, enroll me in Direct Deposit. Checking Savings **Name of Bank:** _____

Transit Routing # (First 9 digits on the bottom of your check) Account #

Yes, I authorize BenefitHelp Solutions to share my Protected Health Information (PHI) information with:

Protected Health Information Authorization **Name:** _____ **Relationship:** _____
Last First

For the purpose of: Any and all information Only eligibility and balance info Only claim status info

Participant Authorization

I have read and agree to the terms and conditions on pages 1 and 2.

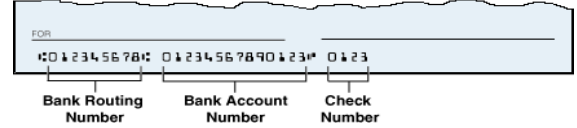
Employee Signature _____ **Date** _____

AUTOPAY

Autopay is an option for you to be automatically reimbursed for your eligible out-of-pocket medical, dental, and prescription expenses processed by ODS Health Plans without having to submit claim forms or supporting documentation. When ODS receives a claim from your provider, they will process and pay the claim according to your plan benefits. ODS will send you an Explanation of Benefits (EOB) and at the same time, send the information to BenefitHelp Solutions for automatic reimbursement of eligible out of pocket expenses. The amount shown on the EOB in the column called *Patient Responsibility* is the amount you will automatically receive -- up to your annual FSA election amount. Orthodontia and IRS ineligible expenses, such as cosmetic procedures, are excluded from AutoPay.

DIRECT DEPOSIT

By having your Health Reimbursement Arrangement Account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a Direct Deposit Remittance Advice. The Remittance Advice will indicate the date your claim was paid, the amount that will be deposited to your bank account and an Explanation of Benefits (EOB). All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for any reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.



PHI - Authorization to Release Reimbursement Account Information to Family Members or Designated Individuals

By completing the Protected Health Information Authorization section and signing this application, I hereby authorize the use and disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to BenefitHelp Solutions. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected under federal law. Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose.

IRS AND OTHER REQUIRED TERMS & CONDITIONS

- ACCEPTABLE FSA PLAN TERMS:** I agree to abide by the terms, conditions and provisions of the Plan contained in the Company's Plan Document. I acknowledge my right to examine the Plan Document or obtain a copy from my Human Resources department.
- AUTOPAY:** I and my eligible dependents are only covered under ODS Health Plan for our health insurance. I do not have a non-tax-dependent domestic partner enrolled on my health insurance. *(If you have a non-tax-dependent domestic partner (per IRC 152d) enrolled on your health plan, you are not eligible to enroll in AutoPay. Per the IRS, non-tax-dependent domestic partner health expenses from health reimbursement arrangement account are not reimbursable.)* Because of complications with Coordination of Benefits, you cannot enroll in AutoPay if you or your eligible dependents are covered under more than one medical or dental insurance plan. I understand that my enrollment in AutoPay will automatically renew each year unless electing to opt out. I understand that my enrollment in AutoPay will be terminated upon leaving employment. If I elect COBRA, I will need to submit my claims manually.
- HSA CONTRIBUTIONS:** I understand that if my children, spouse, or I participate in an HSA Plan, HSA contributions may be disallowed if any HSA Participants also participate in the Health Reimbursement Arrangement Account.