

BENEFITHELP

Solutions

FSA AUTOPAY ENROLLMENT FORM

Participant's Name *(please print)*

Social Security Number

Employer Name

ODS Medical Group Number

ODS Dental Group Number

By enrolling in the Flexible Spending Account (FSA) AutoPay option, you will receive automatic payment for eligible IRC § 213 medical, dental and prescription expenses processed by ODS Health Plans for you and your eligible dependents. Orthodontia expenses are excluded from AutoPay.

Dual Coverage: Because of complications with Coordination of Benefits, you cannot enroll for AutoPay if you or your eligible dependents are covered under more than one medical or dental insurance plan. You will also be required to disenroll if you or your eligible dependents enroll with another insurance plan in addition to your ODS Health Plan.

Domestic Partner: If you have a domestic partner enrolled on your health plan, you are not eligible to enroll in AutoPay. Per the IRS, domestic partner health expenses from healthcare flexible spending accounts are not reimbursable

By signing this enrollment form, I acknowledge and understand the following:

1. I (and my eligible dependents) are only covered under ODS Health Plan for our health insurance. I do not have a domestic partner enrolled on my health insurance.
2. The medical, dental and prescription expenses will not be reimbursed or are not reimbursable under any other health plan coverage and will not be claimed as an income tax reduction.
3. If it is determined that a reimbursed claim is an ineligible expense, I will be liable for repayment to my Flexible Spending Account or will be subject to all applicable income taxes on amounts paid which relate to such expenses.
4. I understand that my enrollment in AutoPay will automatically renew each year. It is my responsibility to notify my employer if I, or my dependents, become eligible for other health plan coverage during the flex plan year or at renewal. I will be disenrolled in the AutoPay option upon notifying BenefitHelp Solutions of other insurance coverage and will be required to send claim forms and documentation manually.
5. 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.

AUTHORIZATION TO RELEASE HEALTH INFORMATION:

I authorize ODS Health Plans to release medical, dental and prescription claim information to BenefitHelp Solutions in order that I may receive automatic reimbursement for my portion of any allowable IRC § 213 medical expenses. I understand that this information will only be used by BenefitHelp Solutions to process the IRC § 213 claims reimbursements on my behalf.

Participant's Signature

Date

To disenroll in the AutoPay option, call Member Services at 503-219-3679 or 888-398-8057, or send us an email, fax or letter requesting to have this option removed. Removal will be effective immediately and reimbursement requests will need to be sent in manually.