AMERIFLEX

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REQUEST FOR SERVICE FORM (Please check only the boxes that apply.)

GENERAL INFORMATION

Company Name: _____

Employee Name: _____ Telephone: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Employee Social Security Number: _____ Email: _____

Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

**Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires AmeriFlex to report certain HRA enrollment data to the Centers for Medicare and Medicaid Services.*

☐ NAME/ADDRESS CHANGE

New Name: _____ New phone: _____

Must be accompanied by supporting legal documentation (i.e. marriage certificate, legal name change certificate)

New Address: _____

City: _____ State: _____ Zip: _____

☐ CHANGE TO BENEFIT AND/OR ELECTION AMOUNT

Please briefly explain the requested change. Examples include: add single health coverage; drop family health coverage; change from single to family health coverage; increase/decrease FSA by $20/pay. Note that the explanation in "Other" may not qualify as an acceptable change in family status under IRS regulations. The requested change must be necessitated by the Family Status Change indicated.

☐ Marriage ☐ Divorce ☐ Legal separation from my spouse ☐ Death of my spouse

☐ Birth of a child ☐ Legal adoption of a child ☐ Death of my dependent ☐ My dependent has lost their coverage

My spouse has: ☐ terminated employment ☐ commenced employment ☐ switched from part to full-time (or opposite) ☐ changed shifts ☐ taken an unpaid leave of absence ☐ had a significant change in family health coverage attributable to his/her employment

I have: ☐ changed shifts ☐ switched from part to full-time (or opposite) ☐ moved from my HMOs service area ☐ taken an unpaid leave of absence

☐ Other - briefly explain change in family status: _____

Change Detail

Benefit Type: _____ Payroll Date of Change: _____

Change From: _____ Change To: _____ (annual)

Change From: _____ Change To: _____ (per pay)

Benefit Type: _____ Payroll Date of Change: _____

Change From: _____ Change To: _____ (annual)

Change From: _____ Change To: _____ (per pay)

REQUEST FOR SERVICE FORM continued . . .

☐ ADDITIONAL CARD REQUEST/CARD TERMINATION (only applicable if your employer has chosen this option)

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meets the IRS eligibility guidelines below:

1. For federal tax purposes, a "spouse" is defined as, ". . . a person of the opposite sex who is a husband or wife." Same sex domestic partners are not considered spouses for purposes of FSA administration. A person residing in the employee's home, who the employee provides over half of their support, who is not the employee's spouse, under applicable state law and is not a family member, is considered a dependent under Internal Revenue Code 152.
2. For federal tax purposes, a "dependent" includes any relative of the participant for whom the participant provides over half of their support for the calendar year. "Relative" includes children, parents, stepchildren, stepparents, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be of a certain age or infirmity; they need only to be persons for whom the participant has provided over half of their support.

Add ☐ | Term ☐ Spouse Name: _____ SSN: _____ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) _____

Telephone: _____ Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

All Dependents must be over the age of 18 in order to receive the AmeriFlex Convenience Card ®

Add ☐ | Term ☐ Dependent Name: _____ SSN: _____ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) _____

Telephone: _____ Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

Add ☐ | Term ☐ Dependent Name: _____ SSN: _____ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) _____

Telephone: _____ Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires AmeriFlex to report certain HRA enrollment data to the Centers for Medicare & Medicaid Services.

☐ DIRECT DEPOSIT- AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS

I, hereby authorize AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my Bank Account indicated below at the depository financial institution named below, hereinafter call DEPOSITORY, and to debit and or credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge that the origination of ACH transactions to or from my account must comply with the provisions of U.S. law. Depository information will be kept on file for future claims. Please complete a new form if your Bank or Account information change.

Depository Name: _____ Account Name: _____

City: _____ State: _____ Zip: _____

Routing Number: _____ Account Number: _____
(always 9 digits)

▶ **SELECT ONE** ☐ Checking Account ☐ Savings Account

If you would prefer, please attach a voided check.

CHECK EXAMPLE

⑆123456789 ⑈0000123456 ⑈1234

routing number account number check number

Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

Please note: Only Benefit/Election amount changes require Employee AND Employer approval.

Employee Signature _____ Date _____

Employer Signature _____ Date _____

This agreement is subject to the terms of my Company's Flexible Benefits Plan, as amended from time to time, and as governed under applicable laws. This amendment revokes any prior election and agreement relating to such plan(s). By signing this form, I agree to the terms and procedures of my Company's Flexible Benefits Plan.