A division of Educators Financial Services, Inc.

3125 Airport Parkway, Cambridge, MN 55008
Metro: 763-552-6053 Toll Free: 888-507-6053 Fax: 763-552-6055
www.ebcsolutions.com

Section 125 Flexible Benefits Plan – Orthodontia Form

For Plan Year Ending: ________________________ **Employer:** ______________________

Name: ____ **SSN:** _____________________

Address: ____

Use this worksheet to determine the amount of orthodontia expenses that can be claimed during the upcoming plan year under your Section 125 Flex Plan.

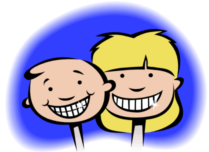
This worksheet assumes your payments are calculated after your insurance benefits have been applied. Please contact us at 763-552-6053 with any questions.

Patient Name: ____

Relationship to Employee: __________________________________

Orthodontia Provider: ______________________________________

Treatment Start Date: ______________________________



____________________	÷	____________________	=	______________________
Total Expense		**Months of Treatment**		**Average Monthly Cost**
____________________	x	____________________	=	______________________
Average Monthly Cost		**Months in Plan Year**		**Annual Election**

I declare that the information I have furnished above is, to the best of my knowledge and belief, true, correct and complete.

______________________________________ ________________________

Signature **Date**

EBC ORTHO 03/05