Please complete the form below to elect to have remaining out-of-pocket health care expenses automatically reimbursed under your Health Flex Spending Account of your employer's Cafeteria Flex Plan.

If you complete and return this form, we will automatically process any claims from the Explanation of Benefits issued by your medical insurance provider that are not automatically reimbursed by the Health Reimbursement Arrangement (HRA) Plan. You need only submit a Cafeteria Flex Plan claim form for health care expenses that have not been submitted to your Medical Insurer, such as eye care or dental expenses.

If you do not complete and return this form, you must submit a valid Cafeteria Flex Plan claim form each time that you wish to receive a reimbursement from the Cafeteria Flex Plan.

If you have any questions, please contact our office at (319) 352-1623 or at (800) 383-1623 if you are outside of the Waterloo-Cedar Falls area.

Sincerely,
Advantage Administrators

? I agree to use my Employer's Health Insurance Carrier as third party provider of information and direct that any individual claim liability be automatically filed as a claim with my Cafeteria (Section 125) Health Care Reimbursement Plan account. I certify that the medical expenses submitted to my Insurer have not been reimbursed and are not reimbursable under any other health plan coverage. I fully understand that I am fully responsible for the sufficiency, accuracy and veracity of all information relating to medical claims submitted to my Insurer and that if any expense for which payment or reimbursement is made is not a proper expense under the Plan, that I may be liable for payment of all related taxes, including federal, state or local income tax on amounts paid from the Plan which relate to such expense.

? Do not file any individual claims not paid by my Insurer with my Cafeteria (Section 125) Health Care Reimbursement Plan account. I understand that all reimbursement claims for any medical expenses must be initiated by me with a completed claim form and appropriate documentation.

_____ _____
Employee Signature Date

_____
Employee Name (Typed or Printed)

_____
Employer Name

LetterheadFooter-Advantage Administrators