



**Health Care Flexible Spending Account
Automatic Reimbursement Option
Authorization Form**

I am enrolled in my employer's Health Care Flexible Spending Account (FSA) plan administered by ASIFlex. I hereby authorize ASIFlex to treat my claims as if they are made under either the medical, prescription and/or dental plan as well as my FSA. This allows eligible medical, prescription and/or dental expenses that are processed through my employer-sponsored health plans to be automatically applied to my available health care FSA dollars and automatically reimbursed to me.

ASIFlex will use the Health Care FSA to automatically reimburse me for deductible, coinsurance and copayment amounts eligible under IRC Section 213(d). Furthermore, I certify that:

- **I have no other insurance coverages except those from my employer.** No family members covered under my medical, prescription and/or dental contracts have other insurance which covers the charges referenced above. If other coverage is obtained during the plan year, I will notify my employer immediately and revoke this agreement.
- Neither I nor my spouse, nor my dependents, make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else.
- I will not submit manual claims to ASIFlex for charges that will be processed by my employer-sponsored medical, prescription and/or dental plans, since these claims will automatically be forwarded to my Health Care FSA.
- I understand that previously processed claims will not be automatically reimbursed. Claims incurred prior to the effective date of this authorization will not be reimbursed through this program and must be submitted manually.

This election shall remain in force until revoked by me.

Name (*Please Print*)

Employer

Social Security Number

Signature/Date

To revoke an authorization for automatic reimbursement already in effect, please check the box below and provide the requested information above.

I wish to revoke my authorization for automatic reimbursement.

Mail or fax to:
ASIFlex
PO Box 6044
Columbia, MO 65205-6044
Fax: 1-877-879-9038

OR

To expedite your authorization, sign up online!
Go to asiflex.com and sign into your account.
Make your authorization under Participant Services.