

AUTHORIZATION FORM

AUTOMATIC REIMBURSEMENT OF DEDUCTIBLES, COINSURANCE, AND CO-PAY AMOUNTS

This authorization form will authorize PayFlex to automatically reimburse you from your health flexible spending account (FSA) without additional claim filing for any deductible, coinsurance and co-pay amounts incurred under your group medical plan with Blue Cross and Blue Shield of Nebraska.

As you incur medical expenses, have the provider submit the claim to your medical insurance plan for processing. When the claim is processed, PayFlex will receive notice of those amounts applied toward your out-of-pocket deductible, coinsurance or co-pays and will reimburse you for those amounts. If any portion is denied as "non-covered", you will need to complete and file a claim form with PayFlex.

Note: This authorization will apply only to the group medical plan. Claims must be filed for other non-medical expenses such as vision, dental or day care services. If you have other individual medical coverage, or medical coverage provided through a spouse plan, you must complete and file claim forms and will not be eligible for this option.

Instructions: Please check the "YES" or "NO" box below to indicate if you wish to participate in the automatic reimbursement option.

YES

I authorize Blue Cross and Blue Shield of Nebraska (my medical insurance carrier) to transfer to PayFlex the information necessary in paper or electronic media, and further authorize PayFlex to automatically reimburse me from my health FSA for any future medical expense claims submitted by my medical insurance plan for myself or my eligible dependents. I understand the expenses must qualify as eligible expenses under the Internal Revenue Code.

By signing this authorization form, I am verifying that I do not have other group medical coverage, and certify that the medical expenses submitted are not reimbursable from any other plan, nor will I seek reimbursement from any other plan. If I acquire other medical coverage at any time, I will notify PayFlex immediately and this authorization will terminate. I agree to refund payments erroneously made and to hold PayFlex harmless for any expense, claim or liability incurred because of such erroneous payment.

NO

I do not wish to participate in the automatic reimbursement feature offered at this time.

Employee Signature

Social Security Number

Date

Employer/Company Name