AUTO-FLEX & DIRECT DEPOSIT

Quick Easy Automatic

Auto-Flex

Sign up for Auto-Flex today and take advantage of hassle free Health Care Flexible Spending Account reimbursements.

No claims to file!

When you are enrolled in the BCC group health plan and have claims applied to your deductible, co-insurance or co-pay, BMI will automatically generate an eligible reimbursement from your Health Care FSA to reimburse you for those patient responsibility expenses. Without ever filing a claim, your FSA reimbursement will arrive soon after your medical or dental claim is final.

It's quick, easy and provides automatic reimbursements of your FSA dollars.

Paper claims are still available at any time and for any eligible FSA expense.

Direct Deposit

Take advantage of our direct deposit feature to obtain quick access to your reimbursement funds.

Sign up today with a Direct Deposit Authorization Form.

With direct deposit, BMI will deposit your Health Care or Dependent Care FSA reimbursements directly into your checking account. You will receive an email notice several days in advance to let you know your funds will be deposited.

Can anyone sign up for Auto-Flex?

Auto-Flex is not available to everyone. If you have other medical or dental insurance, or other options that will reimburse you any portion of your out-of-pocket expenses, you cannot enroll in Auto-Flex.

How can I sign up for Auto-Flex?

Sign up for Auto-Flex by completing the Auto-Flex Election Form and returning the form to Human Resources.

Can I stop Auto-Flex at any time?

Yes. You can change your election for Auto-Flex at any time by completing a new Auto-Flex Election Form and submitting the form to Human Resources.

Do I have to sign up for Auto-Flex and Direct Deposit?

No. You may elect one program independent of the other, both programs at once, or none at all. (Dependent Care FSA reimbursements are not eligible for Auto-Flex.)

BMIFlex

Please indicate if this is a new election or a change in election

_____New Election

_____Change Election

BMIFlex

AUTO-FLEX ELECTION

CAFETERIA PLAN

1. Employer Information

Employer Name: BARTON COMMUNITY COLLEGE BMI 179

2. Employee Information

Employee Last Name: _____ First Name: _____ MI: ___

Employee Social Security Number: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: ( ) _____ Fax: ( ) _____

3. Automatic Reimbursement Election

I ☐ Elect automatic reimbursement from my Health Care Flexible Spending Account (HCFSA).

I understand that by electing this Auto-Flex benefit the administrator will automatically reimburse me for eligible deductible, co-insurance, or co-pay expenses derived from my employer-sponsored group health plan medical or dental claims, up to the amount I elected for my HCFSA.

I understand that if my medical or dental claim is adjusted, resulting in an over-payment to me or my provider, after HCFSA funds have been automatically reimbursed, I may be responsible for repayment of such Flexible Spending Account funds. The Plan Administrator may request that I make repayment by remitting the amount requested or my employer may deduct the amount from my wages.

Automatic reimbursement is not available if you have other insurance and/or options that will reimburse you for any portion of your out-of-pocket expenses. You must file a separate request for reimbursement from your Cafeteria Plan Account with the appropriate documentation from third party.

Employee Signature: _____ **Date:** _____

BMI
Benefit Management Inc.

Flexible Spending Account
Direct Deposit Authorization Form

Fax or mail the completed authorization form with a voided check from your checking account or a deposit slip from your savings account to: Benefit Management, Inc. / Attn: FSA Claims Dept. / PO Box 1090 / Great Bend, KS 67530 / (620) 792-7053 (fax).

Last Name _____ First Name _____
Address _____
City _____ State _____ Zip Code _____
Employer Name_____

Email Address* (This information is required) Notification of processing and fund transactions will be sent via email.

_____

Social Security Number _____-_____-_____

Work Phone _____-_____-_____

Effective Date _____-_____-_____
Month - Day - Year

New Request ☐ Change Request ☐ Cancel Request ☐

Name of Financial Institution
_____

Checking Account Number_____

Routing Number_____ Account Ownership ☐ Individual ☐ Joint

Terms And conditions:

1. Your financial institution must be a member of an Automated Clearing House in order for you to participate in the FSA Direct Deposit Program
2. You must complete this authorization form in its entirety. A signed and dated form along with a voided check for checking account is required for processing. Please allow up to 4 weeks to process this request. Claims submitted during the implementation period will be processed and reimbursed with a written check that we will mail to you.
3. Claims status can be checked by going to our website www.bmikansas.com or calling (888)-922-4622.
4. If an electronic transfer is returned to BMI or for any reason cannot be deposited to your account, BMI will investigate the cause and if necessary, will issue and mail a reimbursement check to you. Pending resolution of the electronic transfer problem, you will continue to receive reimbursement checks in the mail. Reinstatement in the FSA direct deposit program will be determined on a case-by-case basis.
5. It is your responsibility to notify BMI immediately of any changes in your account.
6. You may cancel your participation in the FSA direct deposit program at any time by completing this form indicating the action is to cancel.
7. BMI reserves the right to cancel your participation in the FSA direct deposit program automatically. Your financial institution may also cancel this agreement.

I certify that I have read and understand the terms of this agreement. I authorize BMI to initiate credit entries to the account indicated above for the purpose of reimbursement from my flexible spending account.

Signature_____Date_____

If the account is a joint account or in someone else's name that individual must also agree to the terms and sign below.

Signature_____Date_____

Don't Forget to include a Voided Check.