Flex Corp

820 Gessner, Suite 1225, Houston, Texas, 77024
Toll Free: 1-866-401-5272 | Fax: 866-254-2942
www.bpas.com

Third Party Information Release Authorization

Purpose: The purpose of this form is to allow Flex Corp to release information related to your Medical Reimbursement Account to the specific person(s) designated on this form (such as a spouse, family member, someone else closely involved in your medical care or an unrelated third party). Completion of this form will allow Flex Corp to communicate with such individual(s) who may contact us on your behalf. Related information includes account balance, payment amounts, date paid, and information specific to receipts received. The designated person(s) will be required to provide specific identifying information and should indicate there is a signed authorization form on file.

Participant Information: (Please Print)

Participant Name: _____

Employer Name: _____

Home Address: _____

Phone No.: _____

Last 4 Digits of Social Security No. or Full Alternate ID: _____ **Date of Birth:** _____

I understand if the person(s)/entity authorized to receive information is not bound by HIPAA, the release in information may no longer be protected by federal privacy regulations.

Person(s) authorized to receive information: (Please Print)

Name: _____

Relationship: _____

Address: _____

_____

Date of Birth: _____

Name: _____

Relationship: _____

Address: _____

_____

Date of Birth: _____

Signature:
After completing the above information, please sign and date authorization form.

1. I understand that this authorization will stay on file and will not expire until I send a written request to revoke this authorization to address or fax number set forth below.
2. I understand that I may revoke this authorization at any time by notifying Flex Corp in writing. Flex Corp may take action in reliance on this authorization prior to receipt of my written revocation of this authorization. Therefore, I understand that changes will not be considered applicable before Flex Corp's receipt of the revocation.
3. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or affect eligibility for benefits.

_____ _____
Signature of Participant **Date**

For your convenience you may fax this form to 866.254.2942, or send it via mail to: Flex Corp 820 Gessner, Suite 1225 Houston, TX 77024. For faster processing you may go to www.bpas.com, roll over the Participant Accounts tab and select Flex Account from the drop down menu. Click on the link: Account Access and log into your personal account. After you have logged into your account, roll over the My Account tab and click New Claim and upload this form through the claim area.