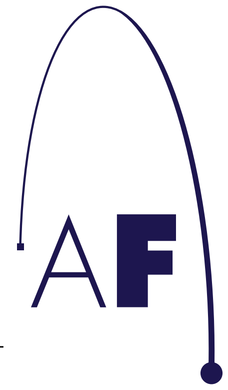
Please submit to:
Email: service@flex125.com
Fax: 800.282.9818
Mail: 700 East Gate Dr. Suite 510
Mt. Laurel, NJ 08054



REQUEST FOR SERVICE FORM
(Please check only the boxes that apply.)

GENERAL INFORMATION

Company Name: ______________________________

Employee Name: ______________________________ Telephone: ______________

Employee Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Employee Social Security Number: ______________ Email: ______________

Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): ______________

**Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires AmeriFlex to report certain HRA enrollment data to the Centers for Medicare and Medicaid Services.*

☐ NAME/ADDRESS CHANGE

New Name: ______________________________ New phone: ______________

Must be accompanied by supporting legal documentation (i.e. marriage certificate, legal name change certificate)

New Address: ______________________________

City: ______________ State: ______________ Zip: ______________

☐ CHANGE TO BENEFIT AND/OR ELECTION AMOUNT

Please briefly explain the requested change. Examples include: add single health coverage; drop family health coverage; change from single to family health coverage; increase/decrease FSA by $20/pay. Note that the explanation in "Other" may not qualify as an acceptable change in family status under IRS regulations. The requested change must be necessitated by the Family Status Change indicated.

☐ Marriage ☐ Divorce ☐ Legal separation from my spouse ☐ Death of my spouse

☐ Birth of a child ☐ Legal adoption of a child ☐ Death of my dependent ☐ My dependent has lost their coverage

My spouse has: ☐ terminated employment ☐ commenced employment ☐ switched from part to full-time (or opposite) ☐ changed shifts
☐ taken an unpaid leave of absence ☐ had a significant change in family health coverage attributable to his/her employment

I have: ☐ changed shifts ☐ switched from part to full-time (or opposite) ☐ moved from my HMOs service area ☐ taken an unpaid leave of absence

☐ Other - briefly explain change in family status: ______________________________

____

Change Detail

Benefit Type: ______________ Payroll Date of Change: ______________
Change From: ______________ Change To: ______________ (annual)
Change From: ______________ Change To: ______________ (per pay)

Benefit Type: ______________ Payroll Date of Change: ______________
Change From: ______________ Change To: ______________ (annual)
Change From: ______________ Change To: ______________ (per pay)

REQUEST FOR SERVICE FORM continued . . .

☐ **ADDITIONAL CARD REQUEST/CARD TERMINATION** (only applicable if your employer has chosen this option)

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meets the IRS eligibility guidelines below:

(1) For federal tax purposes, a spouse includes all legally married same-sex or opposite-sex spouses, regardless of state residence.

(2) A "dependent" generally includes any relative of the participant for whom the participant provides over half of their support for the calendar year. A relative includes children, parents, stepchildren, siblings, aunts, uncles, cousins, and in-laws of the participant. R to reside with the participant in order to be dependents, nor do they need to be a certain age or infirmity; they need only to whom the participant has provided over half of their support.

Add ☐ | Term ☐ Spouse Name: ______________ SSN: ______________ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) ______________

Telephone: ______________ Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): ______________

All Dependents must be over the age of 18 in order to receive the AmeriFlex Convenience Card ®

Add ☐ | Term ☐ Dependent Name: ______________ SSN: ______________ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) ______________

Telephone: ______________ Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): ______________

Add ☐ | Term ☐ Dependent Name: ______________ SSN: ______________ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) ______________

Telephone: ______________ Is this person now, or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If "Yes," you must provide this person's Medicare Claim Number (HICN): ______________

**Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires AmeriFlex to report certain HRA enrollment data to the Centers for Medicare & Medicaid Services.*

☐ **DIRECT DEPOSIT- AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS**

I, hereby authorize AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my Bank Account indicated below at the depository financial institution named below, hereinafter call DEPOSITORY, and to debit and or credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge that the origination of ACH transactions to or from my account must comply with the provisions of U.S. law. Depository information will be kept on file for future claims. Please complete a new form if your Bank or Account information change.

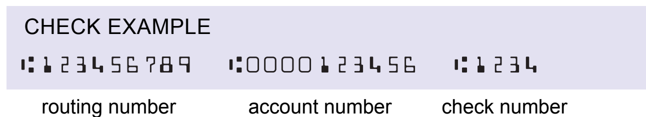
Depository Name: ______________ Account Name: ______________

City: ______________ State: ______________ Zip: ______________

Routing Number: ______________ Account Number: ______________
(always 9 digits)

▶ **SELECT ONE** ☐ Checking Account ☐ Savings Account

If you would prefer, please attach a voided check.



Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

Please note: Only Benefit/Election amount changes require Employee AND Employer approval.

Employee Signature ______________ Date ______________

Employer Signature ______________ Date ______________

This agreement is subject to the terms of my Company's Flexible Benefits Plan, as amended from time to time, and as governed under applicable laws. This amendment revokes any prior election and agreement relating to such plan(s). By signing this form, I agree to the terms and procedures of my Company's Flexible Benefits Plan.