Request for Service Form

Ameriflex

Please check only the boxes that apply.

GENERAL INFORMATION

Company Name:

Employee Name: Telephone:

Member ID (which may be your SSN):

Address:

City: State: Zip: 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)

*Ameriflex to report certain HRA enrollment data to the Centers for Medicare and Medicaid Services.

☐ **NAME ADDRESS CHANGE**

New Name*: _____ New Telephone: _____

*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 spouse ☐ Birth of Child ☐

My spouse has: Terminated employment ☐ Commenced employment ☐

Switched from part to full-time *(or opposite)* ☐ Taken an unpaid leave of absence ☐ Changed shifts ☐

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)*

continued—please check only the boxes that apply.

☐ **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. Relatives do not need 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 be persons for whom the participant has provided over half of their support.

Add ☐ | Term ☐

Spouse Name: Date of Birth:

Member ID (which may be your SSN):

Address to issue card *(if different than participant)*:

Telephone

Is this person now, or has this person ever been enrolled in Medicare?* **YES** ☐ **NO** ☐

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** ☐

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** ☐

*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.

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.

Mail to: **Ameriflex** 7 Carnegie Plaza, Suite 200, Cherry Hill, NJ 08003
Email to: service@myameriflex.com