FLEX PLAN INFORMATION FORM

Employer Name_____ **Phone**_____
Address_____

_____

Contact_____

Flex Plan Administrator_____ **Phone**_____
Address_____

_____

Contact_____
Date of Inquiry_____ **Updated**_____

REIMBURSEMENT DETAIL INFORMATION

How is reimbursement determined? The date charges are incurred?_____
The date payments are made?_____
Maximum dollar contribution cap per year?_____ **Paid out?**_____
Are unused funds carried from one year to the next?_____
Deadline to decide the amount of annual contribution?_____
Is there a difference in the reimbursement schedule for Management Employees?_____
Union Employees?_____**Non Union Employees?**_____
Dependant age limit?_____ **Two employees same employer?**_____
What if another flex plan is involved?_____
Do you coordinate flex benefit reimbursement based on dental plan coverage?_____

What proof do you require for reimbursement? Financial Agreement_____
Statement _____**Receipt** _____**Other**_____
If paid by credit card will you reimburse the employee?_____
Will you make payments directly to the Orthodontic office?_____
Is full reimbursement of the allotment amount made at beginning of year?_____
When?_____ **Or, is it based on the rate deducted from paycheck?**_____
If the treatment fee is greater than the amount contributed during a plan year, will you allow the balance to be paid the following year?_____
Are there any other restrictions or limitations on reimbursement?_____