Whatcom County – Dental Reimbursement Plan Eligibility Update Form

The Plan is an employer sponsored health reimbursement benefit administered by Flex-Plan Services, Inc.

Section I - Employee Information

Name - Last, First, Middle Initial	SSN	Address	City	State	Zip Code

			❑ Add ❑ Drop		*Benefit Amount (Employer use only):*
Date of Birth (MM-DD-YYYY)	Email Address	Phone Number	Action	Effective Date	

Section II - Dependent Information

1								❑Add ❑Drop	
	Last Name	First Name	MI	Sex	Relationship	Date of Birth	SSN	Action	Effective Date
2								❑Add ❑Drop	
	Last Name	First Name	MI	Sex	Relationship	Date of Birth	SSN	Action	Effective Date
3								❑Add ❑Drop	
	Last Name	First Name	MI	Sex	Relationship	Date of Birth	SSN	Action	Effective Date
4								❑Add ❑Drop	
	Last Name	First Name	MI	Sex	Relationship	Date of Birth	SSN	Action	Effective Date
5								❑Add ❑Drop	
	Last Name	First Name	MI	Sex	Relationship	Date of Birth	SSN	Action	Effective Date

Do you or any members of your family have other dental coverage? ❑ No ❑ Yes	**Insurance Company Name / Group Name & #:**
Names of Covered Family Members:	**Effective Date of Coverage / Termination:**

Section III – Direct Deposit Information

- All direct deposits will be initiated on the same day as the normal check reimbursement date.
- Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information are assessed a $10.00 fee.
- If you already have your correct bank information on file with us then you do not need to complete this section.

❑ YES, I would like reimbursements to be issued electronically to my bank account

		❑ Checking ❑ Savings
Routing Number	Bank Account Number	Type

I understand that Health Reimbursement Arrangement reimbursements will be available only for "qualifying medical care expenses" for myself, spouse, and dependents. The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information please contact your employer. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement are not a qualifying expense. I also agree to indemnify and reimburse the Employer for any liability incurred for my reimbursement of a non-qualifying expense.

YES, the above benefits have been explained to me and I elect to participate as indicated:

X_____ _____

Employee Signature **Date**

This enrollment form is to be authorized and submitted to Flex-Plan Services, Inc. by your Human Resources / Benefit Department

Fax: 425-233-6366 Email: elections@flex-plan.com Mail: PO Box 53250 Bellevue, WA 98015