UMass Memorial Health

2025 Orthodontic Reimbursement Plan Enrollment Form

HOW TO ENROLL

Please indicate your benefit elections and update your dependent information. Once your Enrollment Form is complete please select one of the enrollment options below.

ENROLLMENT OPTION 1:
Complete and **FAX** this form to The Employee Benefits Center at **1-866-406-0946**.

ENROLLMENT OPTION 2:
Complete and **EMAIL** this form to:
Support@myFlexDollars.com

If you have any questions regarding your benefit options or need assistance completing your Enrollment Form, please call The Employee Benefits Center at **1-800-307-0230**. Representatives are available to assist you between 8:00 a.m. and 8:00 p.m. EST, Monday through Friday.

EMPLOYEE INFORMATION

Name: _____

Address: _____

_____

Email Address: _____

Phone Number: _____

Employee ID Number: _____

SSN: _____

Date of Birth: _____

Gender: _____

ORTHODONTIC REIMBURSEMENT ACCOUNT ELECTION

You may elect up to $1,000 per plan year for each covered member who receives orthodontic services. UMass Memorial Health will match 50% of your contribution up to $500 per plan year, up to a $1,000 lifetime maximum for each family member receiving orthodontic services. **The Maximum Contribution Allowed is $3,200 per plan year which includes any contributions to a Health Care Flexible Spending Account.**

STEP 1: Please indicate your Total Orthodontia Election and the Employer Match below. (**Total Orthodontia Election does not include the amount you elected for the Health Care Flexible Spending Account.)**

_____ **Total Orthodontia Election**
(Amount you Elected in Workday)

_____ **Employer Match**
(50% of your total Election up to $500)

STEP 2: Use the table below to allocate your total election and the employer match to yourself and/or your covered family members. Please include **all** of the information requested below for each family member that is receiving orthodontic services and will be covered. Your eligible dependents can include your legal spouse and child(ren) up to age 26 regardless of student status, marital status, financial dependence or residence. **Valid Social Security Numbers must be provided at the time of enrollment. Please Note:** Any false or misleading information provided about yourself and/or your dependents as part of the benefits enrollment process may constitute insurance fraud and may be grounds for disciplinary action up to and including termination of employment.

Full Name	SSN	DOB	Relationship	Gender	Employer Match Dollar Amount	Annual Election
			EMPLOYEE	☐M ☐F	$	$
			SPOUSE	☐M ☐F	$	$
			CHILD	☐M ☐F	$	$
			CHILD	☐M ☐F	$	$
			CHILD	☐M ☐F	$	$
			CHILD	☐M ☐F	$	$
			CHILD	☐M ☐F	$	$

PLEASE NOTE: The Health Care Flexible Spending Account and Orthodontic Reimbursement Account election cannot exceed $3,200 combined.

AUTHORIZATION

I have been provided with information related to the benefit option listed on this enrollment form. I have reviewed this information and have understood it. I authorize UMass Memorial Health to reduce my salary by the agreed upon amounts indicated on this form for the Orthodontic Reimbursement Account. I understand that due to provider and/or IRS regulations, my coverage elections are binding until either my employer changes the plan or the duration of the plan year, whichever comes first. I understand that I may only change my coverage elections during the plan year if I experience a Qualifying Life Event, (examples of which include marriage, adoption/birth of a child, divorce, death of a dependent, termination of spouse's employment, etc.) unless my employer changes the plan options offered. I understand that I must report any change in family status that may impact my insurance coverage to Human Resources within 31 or 60 days of the event (depending on the type of event being reported).

_____ **Signature**

_____ **Date**