

Health Flexible Spending Account (HFSA)
Automatic Claim Submission Authorization Form



For Office Use Only

For: Medical
Group Name: Southern Methodist University
Group Number: TX2370
Plan Year Start: 01/01/2005 **Plan Year End:** 12/31/2005

Employee Name: _____ **SSN:** _____
Address: _____ **City:** _____
_____ **State:** _____ **Zip:** _____

You can elect to have expenses that are not covered by your insurance carrier automatically submitted to Ceridian for payment through your Health Care Flexible Spending Account. ***The benefit of Auto Claim Submission is that you do not need to submit paper claims for these expenses.*** Please sign and return this form to take advantage of this option.

By my signature below, I request that my insurance carrier present a report, detailing each medical expense I have presented under its plan for myself or an eligible dependent or my spouse that it does not consider reimbursable, to Ceridian. I authorize BCBS-TX to disclose information about the medical care, diagnosis, treatment, or advice provided to me, my spouse, and/or my dependent(s), including, without limitation, information about AIDS or HIV, mental illness, and/or the use of drugs or alcohol. I understand that this authorization is valid for the plan year listed below and may be revoked at any time. I also understand that any information disclosed under this authorization will be made available to me upon request. I further understand that without this authorization BCBS-TX cannot automatically submit my claims and claims for my dependent(s) and/or my spouse to Ceridian for reimbursement from my HFSA.

I certify that each such reported medical expense represents a legitimate medical expense as defined by my employer's HFSA plan. I further certify that I will not seek reimbursement from any other plan of any such medical expense so presented to my FSA, nor will I seek to claim any federal income tax deduction or credit.

I acknowledge that such reports may contain Protected Health Information ("PHI"), as such term is described under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the regulations promulgated there under, all as amended from time to time (collectively, "HIPAA"). To the extent such authorization may be required by HIPAA or other law, I authorize my carrier to release such information to Ceridian

Employee Signature: _____ **Date:** _____

Please fax this authorization form to 1-727-865-3172 or mail to:
Ceridian
FSA Department
Attn: Michael Easley
PO Box 534200
St. Petersburg, FL 33747-4200