the Taben Group
Flex Administration in cooperation with Surency life and health

TabenFlex
AUTOMATIC ORTHODONTIA REQUEST FORM

This form is to be completed for any participant that wants to receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. If participating in automatic reimbursements for these expenses, the benefits debit card cannot be used to pay the provider.

*=Required Fields

Participant Information

*Last Name, First Name, MI (Please Print)	*Employer	*Social Security Number or Employee ID (EID) as appropriate
*Street Address	*City, State, Zip	

Orthodontia Information

*Start Date of Treatment (mm/dd/yyyy)	*End Date of Treatment (mm/dd/yyyy)	*Monthly Out of Pocket Expense	*Person Receiving Orthodontic Services/Treatment

***Please select only one**

☐ **Contract Attached**: I have attached a copy of the contract or payment plan for my qualifying dependent for which orthodontic services are being provided. Please skip Orthodontia Certification Section.

☐ **Orthodontists Signature**: My orthodontist has completed and signed Orthodontia Certification.

☐ **Stop Automatic Orthodontia**: I have previously enrolled in automatic reimbursement and request that it be stopped effective _____ (mm/dd/yyyy).

Orthodontia Certification (To be completed if Orthodontists Signature box is checked above)

I, _____ certify the information provided on this form is accurate and that services are being provided to the specified individual through the dates provided. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

Orthodontist Signature _____ Date _____

Participant Information

To the best of my knowledge the provided information is complete and accurate. I certify that the request I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that the Taben Group, including it agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify the Taben Group. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

*Participant Signature _____ *Date _____

Return form to: The Taben Group
C/O Surency Life & Health
PO Box 789773
Wichita, KS 67278-9773
www.taben.com
Customer Service: 855-826-8692
Fax: 316-462-3392