Automatic Reimbursement Waiver/Election Change Form

If you elected a health care flexible spending account (HCFSA) and are also participating in your employer's UMR-administered plans, you are enrolled in automatic reimbursement. Under this option, out-of-pocket expenses, such as copays, deductibles and coinsurance, will automatically be applied to your FSA. If you choose not to take advantage of this benefit, please complete this form and return to UMR by fax, e-mail or the address indicated below.

Note: You need to waive the automatic reimbursement option if you will be coordinating benefits with another health or dental plan, or if you have a dependent under your plan that may not be an eligible IRS dependent. Please refer to your Summary Plan Description or contact your tax advisor to verify who would be an eligible dependent.

Member Information (Please Print or Type)

Name _____ UMR Identification Number _____

☐ I wish to waive automatic reimbursement.

☐ I wish to stop automatic reimbursement, effective _____.
MM/DD/YYYY

Authorization

I also understand that the health care flexible spending account elections indicated on this form will remain in effect until a change is requested.

Signature _____Date _____

If you have any questions, please contact your customer service department at the number listed below.

PHONE: 800-826-9781
FAX TO: 877-390-4782 (toll-free)
SEND TO: UMR • P.O. Box 8022 • Wausau, WI • 54402-8022
E-MAIL INQUIRIES: umr-fsa@umr.com