

REIMBURSEMENT AUTHORIZATION AGREEMENT

Mail to:
UPMC Health Plan
PO Box 3169
Greenwood Village, CO 80155-3169

Phone: 1-888-876-2756
Fax: 1-866-229-3711

No. of pages _____

PLAN INFORMATION

EMPLOYER NAME: _____

EMPLOYEE INFORMATION

First Name MI Last Name

Member ID Number Daytime Phone Number Email Address*

*Email: By providing your email address you agree to receive *MyFlex Advantage* correspondence electronically. UPMC Health Plan does not share, sell or divulge individual private information to any third party. All individual private information, including your email address is used solely to administer your FSA account(s). Please add our email address, myflex@upmc.edu, to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your email address by contacting Member Services at 1-888-876-2796, Monday-Friday 7 a.m. to 7 p.m. and Saturday 8 a.m. to 3 p.m.

DEPOSIT INFORMATION

Please choose one method for UPMC Health Plan to use when issuing your reimbursements:

- I would like CHECKS issued for my reimbursements
 I would like DIRECT DEPOSIT issued for my reimbursements (complete below)

Bank Name Branch

City State Zip

Account Number Routing Number (Must be 9 digits)

Checking Savings

NOTE: The initial direct deposit may take up to 10 days to process. Subsequent direct deposits normally take 2 business days from the date of initiation. Bank holidays/weekends may affect when your deposit is credited to your account. Please contact your bank to verify all deposits are received. If you provide us with your email address we will inform you each time a Direct Deposit is initiated. Direct Deposits cannot be posted to debit or credit cards.

EMPLOYEE AUTHORIZATION

I hereby authorize UPMC Health Plan, Inc. to update my reimbursement information according to the direction given above. This may include the issuance of checks or the initiation of credit entries for depositing my Flexible Spending Account reimbursements into my account designated above and, if necessary, making corrections for any entries made to my account in error. This authority is to remain in full force and effect until UPMC Health Plan has received written notification from me of its termination or change in such time and in such manner as to afford UPMC Health Plan a reasonable opportunity to act on it. The most currently dated document on file at UPMC Health Plan will prevail. Any direct deposit remitted by UPMC Health Plan and not rejected by your bank is deemed a valid reimbursement and will not be adjusted.

Signature: _____ Date: _____