Claims Exchange Election Form

Employer Name: ____

Participant Name (First, MI, Last): ____________________________________

Social Security Number: ______ - ______ - __________

Address: ____

City, ST, ZIP: ____

Date of Birth: ________/________/________ Phone Number (______) ________________

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claims Exchange

Check with your employer to see if your Plan qualifies for Claims Exchange. Claims Exchange is also called A.C.T. which stands for Automatic Claims Transfer. Claims Exchange is an automated claims payment feature where certain out-of-pocket expenses may be automatically transferred to your FSA/HRA account by your insurance provider. To activate claims exchange your Social Security number must be on file with your insurance provider. Claims Exchange can apply to you and/or your eligible spouse/dependents. Claims Exchange may be deactivated for your dependents when they attain a specific age (i.e., age 26).

Claims exchange is not allowable if you or any of your dependents have Coordination of Benefits (COB) with other Plans. Claims exchange does not apply to participants who have a Lifetime Benefit Solutions Debit Card.

Carrier Information

Check the boxes if you are enrolled in any of these benefits through your employer.

❑ Medical ❑ Dental ❑ Vision ❑ Rx

Claims Exchange Election

Please indicate your Claims Exchange preference by checking only one of the boxes below:

❑ No, I do not want to use Claims Exchange
❑ Yes, I want Claims Exchange for both medical and dental claims

Note**: If you have Coordination of Benefits, please check the "No Claims Exchange" box, and submit your claims either on a Reimbursement Request form or file your claim online at **www.lifetimebenfitsolutions.com.

Please be sure to provide your SSN.
For claims exchange to function, please be sure your insurance carrier has your SSN in their system.

Participant Authorization

By submitting this form to Lifetime Benefit Solutions, I certify that my election is based on the terms of my Plan.

Participant Signature: ____ Date: ____________

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 680, Liverpool, NY 13088 or
- **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.