HealthPartners

Automatic Claims Submission Opt Out Request Form

The automatic claims submission feature is the standard default with your plan. This feature submits health, dental and/or pharmacy claims to the Health Reimbursement Account (HRA) or Flexible Spending Account (FSA) for reimbursement without the need to complete a claim form. If you wish to opt out of automatic claims submission, complete the first section below. To go paperless and receive your reimbursements more quickly, complete the direct deposit authorization. If you have opted out previously but would like to take advantage of the automatic claims submission, please complete the second section of this form.

You must opt out of automatic claims submission if either of the following are true:

1. You have dual health plan coverage through a spouse.
2. You have a dependent covered under your health plan who does not qualify as a dependent under the federal tax code.

Please note that if you have both an HRA and an FSA, opting out will impact both accounts.

To decline automatic claims submission

NO - By signing this section, I am indicating that I DO NOT wish to participate in the automatic claims submission for myself and all dependents on my medical or dental policy. I understand that I will be required to submit claims manually and that I am required to provide full documentation of my claim. Please note: Once you have elected to decline automatic claims submission, there is no need to decline in subsequent years.

Member/Participant Name

Participant SSN

Group Number

Group Name

Employee Signature

Date

Direct Deposit Authorization

Enroll in direct deposit to have your reimbursements put directly into your checking or savings accounts. Go paperless and receive your money sooner! Please read the terms and conditions below.

Type of transaction: ☐ New ☐ Change ☐ Cancellation

Section 1 — To be completed by employee

Last Name	First Name	Middle Initial
Street Address		
City	State	Zip Code
Social Security Number		
Employer Name		

Section 2 — Financial Institution Information

Name of Financial Institution

Name(s) on Account

Routing Number / Transit Number (Please attached a VOIDED check for verification)

Account Number ☐ Savings ☐ Checking

Depositor / Employee Certification

I certify that I have read and understand the terms and conditions set forth on reverse side. By signing this form, I authorize my health reimbursement account and/or flexible spending account reimbursements to be sent to the financial institution named above and to be deposited in the designated account. I further authorize HealthPartners to access this account information as needed for customer service purposes.

Signature Date

Direct deposit services will remain in effect from one plan year to the next until the participant cancels the direct deposit services.

To re-enroll in automatic claims submission

YES - By signing this section, I am indicating that I wish to participate in the automatic claims submission for myself and all dependents on my medical or dental policy. Please note: once you have authorized automatic claims submission, there is no need to re-authorize in subsequent years unless you choose not to participate. You may stop the automatic claims submission at any time during the plan year by submitting a new form and choosing the "decline" option above.

Member/Participant Name

Participant SSN

Group Number

Group Name

Employee Signature

Date

Fax to: 952-883-5026 or 877-624-2287
Mail to: HealthPartners Service Center, CDHP - Mail Route 21104T, P.O. Box 297, Minneapolis, MN 55440-0297