Discovery Benefits®
www.DiscoveryBenefits.com

www.DiscoveryBenefits.com
866-451-3399 · 866-451-3245
PO Box 2926 · Fargo, ND 58108-2926

forms@discoverybenefits.com

Automatic Orthodontia Request Form

This form is to be completed each plan year and as changes occur when the participant wants to receive automatic reimbursement for orthodontia expenses. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider. Please fill out a separate form if requesting automatic reimbursement for additional family members.

* = Required Fields

Step 1: Participant Information

*Participant Name (First, MI, Last)

*Social Security Number

*Employer Name (Do Not Abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at www.DiscoveryBenefits.com.

Step 2: Orthodontia Information

*Start Date of Treatment (mm/dd/yyyy)

*End Date of Treatment (mm/dd/yyyy)

Note: The start and end dates of treatment must be within the current plan year.

*Person Receiving Orthodontic Services/Treatment

$ *Monthly Cost of Treatment

*Please select only one of the following:

☐ **Orthodontist Signature:** My orthodontist has completed and signed Step 2a.

☐ **Orthodontic Contract:** My orthodontic contract is attached.

☐ **Stop Automatic Orthodontia:** I have previously enrolled in automatic reimbursement and request that it be stopped effective:

(Insert date above as mm/dd/yyyy)

Step 2a: Orthodontist Certification

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

*Printed Name

*Signature

*Date

Step 3: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests 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 Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. Pursuant to the terms of the plan, benefit payments that are not timely claimed may be forfeited back to the plan.

By submitting this form, I certify the above.

F001

K102