AUTOMATIC ORTHODONTIA REIMBURSEMENT REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 929, Manchester, NH 03105
Phone: 833-232-4673; Fax: 855-370-0670; Email: voyasupport@voya.benstrat.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by WEX Inc. For all other products, administration services provided in part by WEX Health, Inc.

This form is to be completed for any consumer that wants to receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.

STEP 1: ACCOUNT HOLDER INFORMATION

Consumer Name *(Required) (First)* ______________________ *(Last)* ______________________

Employer Name *(Required)* ______________________

Birth Date *(mm/dd/yyyy) (Required)* ______________ Social Security Number (SSN) *(Required) (Last 4 digits only.)* ______________

Daytime Phone *(Required)* ______________ Email ______________________

Permanent Address *(Required)* ______________________

City ______________________ State ________ ZIP ______________

STEP 2A: ORTHODONTIA INFORMATION *(Complete this section for the individual receiving orthodontic services/treatment. If you have multiple individuals receiving treatment, submit each one on a separate form.)*

A. Start Date of Treatment *(mm/dd/yyyy) (Required)* ______________ B. End Date of Treatment *(mm/dd/yyyy) (Required)* ______________

Person Receiving Orthodontic Services/Treatment *(Required)* ______________________

Monthly Cost of Treatment *(Required)* $______________________

Select only one. *(Required)*

☐ Contract Attached: I have attached a copy of the contract or payment plan for each qualifying dependent for which orthodontic services are being provided. Skip Step 2B.

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

☐ Stop Automatic Orthodontia: I have previously enrolled in automatic reimbursement and request that it be stopped, effective ______________ *(mm/dd/yyyy)*.

STEP 2B: ORTHODONTIST CERTIFICATION

I, ______________________, certify the information provided on this form is accurate and that services are being provided to the specified individual(s) through the dates indicated 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.

➡ Orthodontist Signature *(Required)* ______________________ Date *(Required)* ______________

STEP 3: PARTICIPANT CERTIFICATION

To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the Internal Revenue Service (IRS) and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that Voya Financial, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit and that, pending approval, reimbursement will begin the first month following the date of my submission.

➡ Participant Signature *(Required)* ______________________ Date *(Required)* ______________

Mail or fax the completed form and supporting documentation to:
Voya Financial, PO Box 929, Manchester, NH 03105; Fax: 855-370-0670.
Questions? Call Customer Service at 833-232-4673 (Live customer support 24x7).