

Flexible Spending Open Enrollment Debit Card Co-Payment Setup Form

Company Name: _____

Please provide us with the following Co-Payment information for the upcoming Plan year of your Flexible Spending Account Plan. This information is necessary to accurately auto adjudicate medical and prescription drug claims.

As a reminder, Sentinel Financial will be sending emails to participants requesting copies of their receipts for transactions that are not auto adjudicated. If claims paid with the debit card are found to be ineligible, Sentinel Financial will ask participants to pay back the ineligible amount, as well as any transaction fee. If participants do not reimburse the plan for ineligible payments, the card may be suspended.

Please complete the Medical and Prescription Drug Co-payment information below:

Medical: \$ _____ \$ _____ \$ _____ \$ _____

Vision: \$ _____ \$ _____ \$ _____ \$ _____

Dental: \$ _____ \$ _____ \$ _____ \$ _____

Emergency Room: \$ _____ \$ _____ \$ _____ \$ _____

Prescription: \$ _____ \$ _____ \$ _____ \$ _____

Benefits Plan Renewal date: _____