American Health Resources
11 North Second Avenue
St Charles, Illinois 60174

Madrid-Waddington Central School

2016/2017 Flexible Spending Accounts and Dependent Care Accounts

Beginning September 1, 2016, as your Third Party Administrator, American Health Resources (AHR), will administer your health flexible spending accounts (FSA) and/or dependent care spending accounts (DCA).

Upon enrollment AHR will e-mail all participants with instructions on how to access their accounts and how to process claims. Quarterly statements will also be mailed to all participants.

AHR processes claims within 24 business hours! We also determine if claim requests are consistent with federal provisions based on your documentation. If not, we will contact you via e-mail, within 24 business hours, or by letter if your e-mail address is not available, requesting additional information.

There are Three Ways to File Claims (claim forms are not required if filing on-line)

1. On-line at www.ahr.net
2. Fax
3. Mail

There are Two ways to be Reimbursed (or we can pay the Provider directly via check)

1. Direct Deposit (ACH)
2. Check

Please Note: When the Plan Year ends, on August 31st, the Grace Period option allows reimbursement from prior year funds for dates of service in which the expense was incurred from the start of the Plan Year to not later than 2 ½ months following the end of the Plan Year, or November 15th. The Run-Out period to submit claims to AHR for the Grace Period option will end 15 days after the Grace Period ends, or November 30th. (If you terminate employment funds are only available until the last day of the month in which you term.)

Best Regards,

The Staff of AHR
1-800-570-3757 - phone
1-888-815-3921 – fax
www.ahr.net

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www.ahr.net

American Health Resources
North Second Avenue
Charles, Illinois 60174
800-570-3757 phone
888-815-3921 fax

Thank you for choosing American Health Resources as your FSA and DCA Plan Administrator. We look forward to serving you!

To View Your Account On-Line

All participants have access to their individual account on the AHR website. The user id is your last name in capital letters. The password is the last 4 digits of your social security number. If you forget your password please call the claims department, at 1-800-570-3757.

To Process a Claim via Fax or Mail

Participants may fax or mail claims to the address or fax number above using the claim forms provided. If we cannot process the claim we will mail a letter, or send e-mail notification, within 24 hours explaining why the claim was not processed.

To Process a Claim On-Line

Go to www.ahr.net and click on AHR LOG IN. The user id is your last name in upper case letters. The password is the last 4 digits of your social security number. You have 2 options to process a claim: You may submit a "payment claim" or a "reimbursement claim." Either way you will be prompted to attach documentation to verify your claim. A payment claim will be processed via check and mailed directly to your medical provider (you must provide the provider address, patient name, date-of-service, and your patient account number). Reimbursement claims can be processed 2 ways; by check, mailed to your home address, or by Direct Deposit.

Direct Deposit

We now offer two ways to be reimbursed, by check or Direct Deposit! For Direct Deposit please provide your banking information on your claim form or with your on-line claim submission. Funds will be available within 2 business days!

E-mail Notification

For same day e-mail notification, when claims are processed for you, please provide your e-mail address on-line or on your claim form.

Please Note: When the Plan Year ends, on August 31st, the Grace Period option allows reimbursement from prior year funds for dates of service in which the expense was incurred from the start of the Plan Year to not later than 2 ½ months following the end of the Plan Year, or November 15th. The Run-Out period to submit claims to AHR for the Grace Period option will end 15 days after the Grace Period ends, or November 30th. (If you terminate employment funds are only available until the last day of the month in which you term.)

If you need further assistance please call the claims department, at 1-800-570-3757, from 8:30 a.m. – 5:00 p.m. Monday – Friday (CST).

AHR Benefit Election Form
FSA / DCA Plan

American Health Resources
11 N. 2nd Avenue
St. Charles, IL 60174
800-570-3757
888-815-3921 (fax)

For AHR Use Only:

Date received
Group Number
Member Number
Effective Date

Enrollment Information

Employer Name		Company Representative	Phone Number
MADRID-WADDINGTON CENTRAL SCHOOL		Julie Bresett	315-322-5748
Participant name (last, first, MI)	Social security number	Effective Date	Plan Year:
Participant Address	City, State, Zip	Home phone	Work phone
E-mail Address		Date of Birth	

Election Amounts

Flexible Spending Account: _____ Per pay period, _____ per plan year ($2550.00 annual maximum)

Dependent Care Account: _____ Per pay period, _____ per plan year ($5000.00 annual maximum)

Survivor Beneficiary Information

Primary beneficiary name (last, first, MI)	Social security number	Date of Birth	Relationship
Address	City, State, Zip code	Home phone	Work phone
Secondary beneficiary name (last, first, MI)	Social security number	Date of Birth	Relationship
Address	City, State, Zip code	Home phone	Work phone

Participant Attestation

Pursuant to the AHR Cafeteria Plan ("Plan"), the undersigned elects to become a participant in that Plan. AHR will determine if your request is consistent with federal provisions. If you are changing from a prior election, the new amount you elect should be the total dollar amount of ALL contributions you want deducted for the entire Plan Year. Limited Purpose FSA is limited to Vision and Dental only.

I authorize the amount(s) elected to be deducted from my salary/wages on a pre-tax basis. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Code Section 125, if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for eligible expenses are not filed with AHR by the claims filing deadline date following the 2 1/2 month grace period.

I further understand my enrollment and elections are IRREVOCABLE unless I have a Qualifying Status Change as defined by Federal Code. I understand that I must request such change within thirty-one (31) calendar days of the Qualifying Status Change.

Participant Name (print)	Participant Signature	Date