AUTHORIZATION FOR THE AUTOMATIC REIMBURSEMENT OF
DEDUCTIBLES, COINSURANCE, AND CO-PAY AMOUNTS

Employer Name: **DOMINION (115914)**

Employee Name (please print) _____

SSN or Personnel No. _____

Plan Year:

In accordance with my rights under the Flexible Spending Account Plan, I elect to participate in the Crossover Claims Feature that allows Anthem, MetLife Dental, Express Scripts, and EyeMed Vision to send claim data to PayFlex for automatic reimbursement of eligible Flexible Spending Account expenses.

This agreement is subject to the terms of the employer's Cafeteria Plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation redirection agreement relating to such plan.

I certify that:

- I am not covering a Domestic Partner, as these expenses are not allowed by the IRS; and,
- I am claiming reimbursement only for eligible expenses that have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

Employee Signature (required) _____ **Date**_____

MAIL TO: PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158

EMAIL TO: flexmail@payflex.com

FAX TO: 1-855-803-4887