

Group Contact Change Form

Group Information
Group Name: _____
SelectAccount Group #: _____

General Information Change
Check the boxes below next to the information you wish to change:
<input type="checkbox"/> New Group Name: _____
<input type="checkbox"/> New Address: _____
<div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Street State Zip </div>
<input type="checkbox"/> New Primary Group Contact:
<div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Name </div>
<div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Title Phone Fax Email </div>
Make same contact change for: <input type="checkbox"/> Report Contact <input type="checkbox"/> Billing Contact <input type="checkbox"/> File Load Confirmation
<input type="checkbox"/> Add an additional contact below as another authorized contact to call the SelectAccount Group Leader Line.
Name: _____ Name: _____
Name: _____ Name: _____

Report Contact Information Change (Not applicable to HSA or VEBA accounts)
Check the boxes below next to the contact information you wish to change or add to receive claim reimbursement payment reports. This is the report sent weekly by our Accounting Dept. to groups who have payments drawn via ACH (Automated Clearing House) for their employee's FSA/HRA claims.
<input type="checkbox"/> Change Report Contact To: _____
Choose one of the following to receive reports: By Email: _____ or By Fax : _____
<input type="checkbox"/> Add Additional Report Contact(s):
Name: _____
By Email: _____ or By Fax : _____
Preferred Report format: (select only one)
<input type="checkbox"/> Standard Report (lists each employee, by location)
<input type="checkbox"/> Total Only Report (lists totals only, by location)

File Load Confirmation

Change contact email address to: _____ FSA HSA

Billing Contact Change

If someone other than the main group contact should receive the monthly administration fee invoice, complete the section below:

Name: _____

Address to send invoice: _____

Phone: _____

Email: (invoices are mailed only) _____

Agency/Agent Affiliation Change

If your group has a health plan with BCBS of Minnesota, complete the Group Agent of Record Assignment form. All other groups, complete the fields below:

Change Agency To:

Agency Name: _____ Agency Code: _____

Agency Address: _____
Street State Zip

Change Agent To:

Agent Name: _____ Agent Code: _____

Effective Date of Change: _____

Group Contact Signature

Signature Date

Mail or Fax to: SelectAccount, P.O. Box 64193, St. Paul, MN 55164-0193

Fax: 651-662-1180 or 1-866-231-0214

For Questions, call the Group Leader Line at 651-662-2320 or toll-free at 888-460-4013