

Please fill out this form for mid-plan year changes and return in its entirety to SelectAccount 2 weeks in advance of the change effective date. If you have questions on how to complete the form, please call our Group Leader Line at 1-888-460-4013 or our Agent Service Line at 1-888-460-4015.

GROUP INFORMATION (Required)	
Group Name: _____	SelectAccount Group #: _____
Health Plan: _____	

HEALTH PLAN CHANGE AND EFFECTIVE DATE:	
New Health Plan: _____	Effective Date: _____

OPTIONAL FEATURES
<p>The crossover and pay-the-provider election applies across all medical spending accounts (i.e. Medical FSA, HRA, or HSA).</p> <p>Medical Crossover (must have health plan with BCBSMN, BCBS of Kansas, CCStpa or BlueLinkTpa)</p> <ul style="list-style-type: none"> <input type="checkbox"/> New participants are auto-enrolled in medical crossover. (Existing participant elections will not be changed.) <input type="checkbox"/> All participants are auto-enrolled in medical crossover. (If this is selected, participants will be enrolled in crossover as of the date this change is processed. Any participants who have previously declined crossover will need to decline crossover again.) <input type="checkbox"/> Participants elect medical crossover. (highest participant fees apply) <input type="checkbox"/> Do not offer medical crossover. (highest participant fees apply) <p>Delta Dental of Minnesota Crossover (Must have dental coverage through Delta Dental of MN)</p> <ul style="list-style-type: none"> <input type="checkbox"/> New participants are auto-enrolled in dental crossover. (Existing participant elections will not be changed.) <input type="checkbox"/> All participants are auto-enrolled in dental crossover. (If this is selected, participants will be enrolled in crossover as of the date this change is processed. Any participants who have previously declined crossover will need to decline crossover again.) <input type="checkbox"/> Participants elect dental crossover. <input type="checkbox"/> Do not offer dental crossover. <p>Pay-the-provider (must have health plan with BCBSMN and medical crossover)</p> <ul style="list-style-type: none"> <input type="checkbox"/> All Participants are auto-enrolled in pay-the-provider. Additional fee applies to all participants regardless of their pay-the-provider election. Must also select one of the auto-enroll options in medical crossover. (Participants may opt out of pay-the-provider by completing the pay-the-provider Election Form, F9089.)* <input type="checkbox"/> Offer pay-the-provider to participants. Additional fee applies to all participants regardless of their pay-the-provider election. Participants may elect pay-the-provider by completing the pay-the-provider Election Form, F9089.)* <input type="checkbox"/> Do not offer pay-the-provider. <p>* If you chose 'All Participants are auto-enrolled in pay-the-provider' and you have an HSA, your HSA election will be defaulted to 'Offer pay-the-provider to participants.'</p> <p>Effective Date of change: _____</p>

DEBIT CARD OPTION

Debit Card Option

- Changing your current debit card option may require current cards to be turned off and new cards will be issued.
- If both medical crossover and debit cards are offered, participants can choose one or the other, not both.
- Participants may elect the debit card by completing the Debit Card Participant Request Form.
- **Select just one:**
 - FSA Only
 - HSA Only
 - FSA & HSA Stacked Account Card
 - Do not offer debit card

Effective Date of change: _____

ADMINISTRATIVE FEES (HSA Only)

For participants who have an HSA stacked with a second SelectAccount product like an FSA or HRA, only the highest fee will apply. The lower participant fee will be waived.

Health Savings Account Plan Options

SelectAccount offers three different options for HSA Accounts. (The fees for each option are listed on the pricing sheet.)

Please select one HSA plan option:

- HSA Premium Saver
- HSA Basic Saver
- HSA Thrift Saver

Participant Fees (if your group offers another medical account with SelectAccount, the fees must be employer paid on a monthly basis.)

- Employer Paid - Indicate billing frequency:
 - monthly
 - annually (recommended for 10 or less participants)
- Participant Paid - (Billed annually and taken from participant's account balance.)

GROUP SIGNATURE

It is agreed that necessary information concerning employees or employees and their dependents participating in or subsequent to the effective date of the Plan and employees whose participation is to be changed or discontinued shall be furnished to SelectAccount on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS FORM. THE INFORMATION PROVIDED ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Authorized Signature: _____ Date: _____

Print Name: _____ Title: _____

Submit this form to SelectAccount by fax at (651) 662-1180 or toll-free fax at 1-866-231-0214, or mail to SelectAccount, PO Box 64193, Saint Paul, MN 55164.