



Wellmark BlueCross BlueShield of Iowa
 Wellmark BlueCross BlueShield of South Dakota
 Independent Licensee of the Blue Cross and Blue Shield Association

Flexible Benefits
 PO Box 93148
 Des Moines, Iowa 50393-3148

BluePriority™ FLEX

For questions or assistance with this form,
 call (800) 624-2755 ext. 4661 or 5209
 Fax (515) 299-5801

For forms and information, visit our website at
www.wellmark.com/flex

Reimbursement Account Flexible Benefits Employer Application including the Flex Debit Card

General Information

Full Legal Name of Employer		Federal Tax I.D.	
Street Address		City, State, Zip Code	
Contact Person	Contact Phone () ()	Contact Fax () ()	E-Mail Address
Business Entity: <input type="checkbox"/> C. Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Subchapter S <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Tax-Exempt Employer			

List any subsidiaries or affiliates to be included in this plan. If more space is necessary, attach a separate sheet.

Name _____ Federal Tax I.D. _____

Effective Date of the Plan

Administration of this plan will begin on ____/____/____ and end on ____/____/____.

(The plan year shall mean a 12 month period. The initial plan year may be less than 12 months.)

If a plan is now in place: current plan year is ____/____/____ to ____/____/____. Original eff. date is ____/____/____.

Benefits to be Offered Under the Plan

A. **Pre-Tax Premium** for: Medical Dental Prescription drugs Term Life insurance
 Disability Cancer Vision Accident Other _____

All premiums through payroll deduction will be pre-taxed.

B. **Pre-tax contributions through payroll deduction to a Health Savings Account (HSA)**

If pre-tax HSA contributions are elected, a Participant may change his or her contribution election:

- By filing a new election form pursuant to the administrative rules established by the Employer.
- Only in connection with a Change in Status or other event permitting benefits election to be changed mid-year under the Plan.

C. **Medical Reimbursement Account** (both General Purpose and Limited Purpose Accounts)

Maximum \$ _____ Minimum \$ _____

Automatic reimbursement option will be provided according to the details on the back of this application.

D. **Dependent Care Reimbursement Account** Maximum \$5,000 Minimum \$ _____

E. **Cash Option/Flexible Credits:** Each Plan Year a Participant may elect to receive in cash up to \$ _____ of the Flexible Dollars, if any, allocated by the Employer to the Plan for the benefit of the Participant.

F. **Prepayment of Orthodontia Claims Option** (see the back of this application for more details) **This option must be selected if Blue Priority Flex Debit Cards are being offered to employees.**

G. **Blue Priority Flex Debit Cards for Medical Reimbursement Accounts**
(Not available for participants who are offered and choose automatic reimbursement)

- Annual Fee and Extra Card Fee paid by Employer
- Annual Fee and Extra Card Fee paid by Employee
- I am a register group which writes checks from my bank account. I will supply my bank account information in Funding Options Available section below. The annual fee and extra card fee will be paid by Employer
- I am a register group which writes checks from my bank account. I will supply my bank account information in Funding Options Available section below. The annual fee and extra card fee will be paid by Employee

Reimbursement Account Processing

For both Medical and Dependent Care Reimbursement Accounts:

- Daily processing for non register groups.
- Bi-weekly processing for register groups.
- Automatic reimbursement claims will be processed weekly.
- Direct Deposit of disbursements will be available to all employees.
- All IRS qualified status changes will be allowed for election changes during the plan year.
- All expenses allowed by the IRS will be eligible except for Limited Purpose Medical Reimbursement Accounts.
- Check minimum during the plan year is \$25.
- Claims runout period should be specified below where noted. This is generally 90 days after the end of the plan year unless you are adopting the grace period. If offering Blue Priority HRAs, run out period is 180 days after the end of the plan year.

Grace Period Processing Information

Claims grace period following the end of the plan year: Yes No

If Yes: Length of grace period _____ months, which is ____/____/____(date).

Maximum is 2 ½ months following the end of the plan year.

Grace Period will apply to:

- Medical Reimbursement Accounts only
- Both Medical & Dependent Care Reimbursement Accounts

Claims run out period following the end of the grace period (or following the end of the Plan year if you do not choose to use a grace period)

- 45 days, which is ____/____/____(date)
- ____ days, which is ____/____/____(date)

Eligibility

Note: Notwithstanding the below, the following Employees can not participate in the Plan, based on the Internal Revenue Code and the Plan terms: self-employed individuals described in Code section 401(c), "2-percent shareholders" of an S corporation (and their family members), sole proprietors, partners in a partnership, and individuals classified by the Employer as independent contractors.

All Employees shall be eligible to participate in the Plan except the following Employees shall *NOT* be eligible to participate:

- No exclusions
- Employees who have not attained age _____
- Employees who have not completed _____ days/months/years of service
- Employees who do not work as least _____ hours per week on a regular basis
- Employees covered under a collective bargaining agreement (Note: If the Employer excludes union employees from the Plan by checking this box, the Employer must be able to produce evidence that welfare benefits were the subject of good faith bargaining)
- Commission salespersons
- Employees compensated on an hourly basis
- Employees compensated on a salaried basis
- Employees who are temporary or seasonal, or who are employed with the understanding that their employment is for a specific period of time or will be terminated upon completion of a specific project
- Other employees (specify) _____

Plan Entry Date

Employees who have met the eligibility requirements on the Effective Date with Wellmark may become Participants in the Plan as of such Effective date.

An Employee who meets the eligibility requirements after the Effective Date with Wellmark may become a Participant (please choose one of the following):

- On the first of the month following the date of hire.
- On the first date of the first payroll period following the date on which the employee meets the eligibility requirements of the Plan.
- On the first day of the first month following the date on which the employee meets the eligibility requirements of the Plan.
- ____ number of days / months / years (please circle one) following the date on which the employee meets the eligibility requirements of the Plan.
- Immediately on the date on which the employee meets the eligibility requirements of the Plan.
- Other (please specify the waiting period)

Definition of Compensation

Following is the generally accepted definition of compensation: the total amount of all payments made by, or on behalf of, an Employer to an Employee for services rendered to the Employer, including bonuses, commissions, overtime pay and salary reduction contributions made under the Flexible Benefits Plan or any other plan of the Employer, but does not include expense reimbursements, fringe benefits provided by the Employer, director's fees, severance pay, contributions made by the Employer for group insurance, self-insured benefits, or to any employee benefit plan.

The above definition is satisfactory OR is not satisfactory.

If not, specify your acceptable definition: _____

Payroll Deduction Schedule

Indicate the payroll schedule(s) used, and the date the first payroll deduction will be made.

- 52 times/year 1st Payroll deduction date _____ / _____ / _____
- 26 times/year 1st Payroll deduction date _____ / _____ / _____
- 24 times/year 1st Payroll deduction date _____ / _____ / _____ 2nd Payroll deduction date _____ / _____ / _____
- 12 times/year 1st Payroll deduction date _____ / _____ / _____
- Other: _____ 1st Payroll deduction date _____ / _____ / _____

Administrative Fees

Standard flexible benefits services will be performed according to the fees agreed upon below:

Please select paper or PDF enrollment materials

- Paper enrollment kits \$ _____
- PDF files of enrollment materials \$ _____

This annual fee includes consulting, IRS non-discrimination testing, standard plan documents, enrollment materials, and plan set up*.

Monthly claims processing fee will be based on the participation range of eligible employees

0% - 10%	\$ _____	31% - 40%	\$ _____
11% - 20%	\$ _____	41% - 100%	\$ _____
21% - 30%	\$ _____		

- Bill me annually (5% discount provided for annual billing)
- Bill me monthly

Blue Priority Flex Debit Card Service Fees:

Annual fee per debit card participant for two debit cards \$ _____

Fee for extra cards (lost, stolen, additional dependents) \$ _____ per card

* An additional charge may be incurred for modifications to our standard documents. Enrollment materials are based on number of eligibles plus 25%; any additional materials will be charged at cost. Forms and brochures are available in PDF format upon request.

Funding Options Available

Please refer to the below funding options for claim reimbursements and select option A, 1, A, 2, B, or C accordingly. Briefly with Options A, 1 and A, 2, employee payroll deductions are electronically transferred to an escrow account from which Wellmark/Visa issues payments to employees. Option B, the employer maintains the payroll deductions in their own bank account and provides banking information for Wellmark/Visa to withdraw funds as needed to make payments to employees. Option C, Employer maintains the payroll deductions and issues payments directly to their employees. With this option, banking information is also required if opting for Debit Cards.

A. All benefits, whether by check, direct deposit, or via the Blue Priority Flex Debit Card, will be made from an escrow account maintained by Wellmark for direct deposit of Plan Sponsor contributions. Wellmark will account for each Employer's funds separately. For funding of the benefit payments, plan sponsor must choose one of the following:

1. Authorize Wellmark's Flexible Benefit Department to initiate an ACH withdrawal of funds from the plan sponsor's bank account into the escrow account. **THIS IS THE PREFERRED METHOD OF FUNDING** as it avoids unnecessary delays in payments to your employees. An ACH Funding Authorization Form will need to be completed.

NOTE: If a plan sponsor chooses this ACH option, the ACH funds transfer will be initiated on the payroll release date(s) based on Payroll Deduction Schedule above.

2. Plan sponsor will wire transfer/ACH funds into an escrow account. (Wellmark will supply the employer with the applicable escrow account and bank information)

IMPORTANT: If adequate funds are not supplied by the plan sponsor in a timely manner, claims payments may be suspended until contribution funding is current.

In addition, if at any time during the plan year, disbursements to employees exceed the amount of contributions made to the Medical Reimbursement Accounts, Wellmark may notify plan sponsor and initiate a request for additional funds to cover the excess. These funds will be returned to plan sponsor later in the plan year when disbursements and contributions are back in balance.

Claim payment information for plan sponsors selecting Option A can be accessed 24/7 at your plan sponsor password protected website www.eflexonline.com.

Funding Options Available

B. All benefit payments, whether by check, direct deposit, or via the Blue Priority Flex Debit Card, will be withdrawn from the following plan sponsor bank account on a daily basis. By providing the information requested below you authorize access to the specified account for benefit payments. The National Flex Trust will withdraw funds needed to pay the flex debit card transactions and Wellmark will prepare the checks/EFTs. The plan sponsor agrees to supply Wellmark with an electronic signature file to use for signing all flexible benefit checks. The plan sponsor is responsible for reconciliation of the plan sponsor bank account through use of reports available on the plan sponsor website www.eflexonline.com. An adequate level of funds must be available in this account daily so as to avoid being assessed a settlement failure fee.

Name of Bank: _____
Address of Bank: _____
Account Representative: _____
Phone Number: _____
Account Number: _____
Routing Number: _____
Printed name of authorized individual: _____
Signature of authorized individual: _____

C. Benefit payments, whether by check, or direct deposit, will be made by the plan sponsor (termed a "register" group). A plan sponsor should contact our office to take advantage of this option which will result in **discounted administration fees**. THIS OPTION SHOULD BE SELECTED IF THE PLAN SPONSOR DOES NOT WISH TO PROVIDE DAILY RELEASE OF FLEXIBLE BENEFIT CLAIM PAYMENTS FOR THEIR EMPLOYEES. Under this option, Wellmark will make available to plan sponsor a report of claims needing payment on a bi-weekly basis.

If you select Option C and have selected the Blue Priority Flex Debit card item G above, benefit payments via the Blue Priority Debit Card will be withdrawn from the following plan sponsor bank account. The National Flex Trust will withdraw funds needed to pay the flex debit card transactions on a daily basis. An adequate level of funds must be available in this account daily so as to avoid being assessed a settlement failure fee.

Name of Bank: _____
Address of Bank: _____
Account Representative: _____
Phone Number: _____
Account Number: _____
Routing Number: _____
Printed name of authorized individual: _____
Signature of authorized individual: _____

Claim payment notification for plan sponsors selecting Option C should be sent to _____ via e-mail. Please provide the e-mail address for the above person _____.

To ensure this information is received by plan sponsors in the event of the above person is out of the office, please provide the name of a back up person _____ and their e-mail address _____.

Enrollment Information

Employer will prepare their own enrollment materials using PDF's provided by Wellmark. Please send these PDF's via email to _____.

Wellmark will prepare enrollment materials based on the following information.

Number of eligible employees: _____ Number of enrollment brochures needed: _____

Send enrollment materials to (name): _____ by date: ____/____/____

Employees should return enrollment forms to (name): _____ by date: ____/____/____

Assistance requested for enrollment meetings: Yes No

Date(s) scheduled for employee meeting(s) if known: _____

ERISA Plan Number

If this plan has chosen to have Medical Expense Reimbursement ERISA Plan Number assigned to the portion of the Plan representing health care reimbursement is (check one)

- 501
- Other _____

Additional Options

Automatic Reimbursement Option

This option allows eligible* medical expenses that have been submitted to your employees' Wellmark Blue Cross and Blue Shield health insurance plan to also be considered as a Medical Reimbursement Account claim. After claims are processed by Wellmark Blue Cross and Blue Shield any remaining unpaid eligible medical expenses will automatically be directed to their Medical Reimbursement Account for further consideration. This option is not available for Limited Purpose Medical Reimbursement Accounts (i.e., if your employee, their spouse, or dependents make contributions to an HSA or receive HSA contributions from anyone else) or employees with a Blue Priority Flex Debit Card.

Program provisions include:

1. **If you offer a Partial Self-Funded plan or do not have Wellmark health coverage you will not be able to utilize this option.**
2. **Employees may not participate in this program if they, their spouse, or dependents make contributions to an HSA or receive HSA contributions from anyone else. However, participants with a Blue Priority HRA can still participate.**
3. Employees may not participate in this program if they or anyone in their family has other insurance coverage.
4. Employees may not participate if they order a Blue Priority Flex Debit Card.
5. If a health insurance claim is adjusted after the original submission, there is a possibility of an incorrect payment. Overpayments will be requested to be returned from participants or offset against future claim submission when possible.
6. Individual Employee authorization is needed to select this option. Employee authorization can be selected on the enrollment form.

Claims to be automatically reimbursed can include any of the following plans **administered** by Wellmark Blue Cross and Blue Shield:

- Medical
- Blue Dental *OR* This option is not applicable as we currently offer partial self-funding or do not have Wellmark health coverage.
- Prescription Drug Plan

* Only co-payments, co-insurance, and deductible are eligible to be reimbursed through the automatic reimbursement program. Contract limitations need to be filed manually by the participant.

Prepayment of Orthodontia Claims Option

This option provides employees with the ability to have eligible pre-paid (i.e. not yet incurred) orthodontia expenses reimbursed from their Medical Reimbursement Accounts instead of reimbursing the pre-paid amount as services are rendered during the term of the orthodontia contract. If this option is selected, it will be available for all employees. Please note: It is recommended by IRS Prop. Treat. Re § 1.125-2 that the reimbursement of orthodontia expenses not occur until services are actually rendered to avoid violating the "expense incurred" requirement. The more liberal approach offered by this option which reimburses orthodontic costs when they are paid is based on informal, non-binding remarks of an IRS representative at a Cafeteria Plan Administrators Symposium in 2001. There is no formal authority which endorses the payment of medical expenses prior to the time services are actually rendered. **This option must be selected if Blue Priority Flex Debit Cards are being offered to employees.**

Service Agreement

I certify that I am legally authorized to sign this flexible benefits employer application on behalf of the employer named herein. The employer hereby agrees to purchase those services indicated on this application at the cost provided in the flexible benefits proposal or fee schedule. The cost quotation provided to the employer was calculated based upon certain representations previously made by the employer including, but not limited to, the flexible benefits services requested by the employer and the number of eligible participants. Wellmark Blue Cross and Blue Shield reserves the right to revise the cost quotation previously provided to the employer if such representations differ from the flexible benefits plan implemented by the employer. A minimum fee of \$150 will be payable if an application is processed but subsequently cancelled.

Signature: _____ Title: _____ Date: ____/____/____

Wellmark Blue Cross and Blue Shield Representative: _____

Broker Name: _____ Company/Agency: _____