



Wellmark BlueCross BlueShield of Iowa
Wellmark BlueCross BlueShield of South Dakota
Independent Licensees 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
Fax (515) 299-5801
For forms and information, visit our website at
www.wellmark.com/flex

Premium Only Plan Flexible Benefits Employer Application

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: C. Corporation LLC Subchapter S Partnership Proprietorship 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

Pre-Tax Premium for: Medical/Dental Group Term Life HSA Other _____

All premiums through payroll deduction will be pretaxed.

Eligibility and Plan Entry Date

Note: Participants in the flexible benefits plan must be employees for FICA and tax withholding purposes. Proprietors, Partners, Subchapter S Corp. owners, Limited Liability Corporation owners, and other self-employed persons are not eligible to participate. Ownership attribution rules may also limit participation of family members who are employees (spouse, children, parents, grandchildren). Otherwise, eligibility and plan entry dates will be determined by the underlying welfare benefit plan for which premiums are being paid pre-tax under this flexible benefit plan.

Administrative Fees

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

Annual administrative service fee: \$ _____

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

*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.

Enrollment Information

Wellmark will prepare your enrollment materials based on the following information.

Number of eligible employees: _____

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

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

Enrollment forms do not need to be sent to Wellmark. The employer must maintain these records.

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 \$100 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: _____