



# ENROLLMENT FORM Hy-Vee and Affiliates Tax Savings Plan

For Office Use Only	Effective Date / /
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## Employee Information

Name		Social Security Number	
Home Address	City	State	Zip
Please check below if one applies to you: <input type="checkbox"/> STORE DIRECTOR <input type="checkbox"/> STAFF MEMBER (offices & Distribution Centers Only)		Work Location	

## Employee Reimbursement Account Agreement

**I elect to enroll** and agree to have my gross salary redirected, in accordance with Section 125 of the Internal Revenue Code, to contribute in the amounts indicated below. I understand that contributions to my reimbursement account(s) can only be reimbursed to me for eligible expenses within each plan year. I further understand that if I do not use the funds in my reimbursement account(s) during the plan year, those funds will not be paid to me, they will be forfeited.

**Medical Reimbursement Account** (Minimum \$25/mo. Maximum \$10,000/yr.) \$ \_\_\_\_\_  
(Annual Election)\*

General Purpose (all qualifying medical expenses) OR  Limited Purpose (vision and dental expenses only)  
You must select a Limited Purpose Account if you, your spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else.

**Dependent Care Reimbursement Account** (Minimum \$25/mo. Maximum \$5,000/yr.) \$ \_\_\_\_\_  
(Maximum per plan year of \$2,500 if married filing separately or \$5,000 if single or married filing jointly; if more than \$2,500 is elected, my signature on this agreement certifies I am single or married filing a joint income tax return with my spouse.)  
For daycare, not dependent's medical expenses.  
(Annual Election)\*

**\* Do not indicate a weekly or monthly amount**

**I elect not to participate.**

## Blue Priority Flex Debit Card

I wish to order a debit card for my Medical Reimbursement Account. I have read the Q&A on flex debit cards and understand my responsibilities. I will not elect Automatic Reimbursement.

## Automatic Reimbursement Authorization (If this section is not marked, previous plan year election will be maintained)

I have read and understand the information on the back of this form regarding automatic reimbursement. I hereby authorize Wellmark Blue Cross and Blue Shield to treat my medical claims as if they are made under both the medical plan and the Medical Reimbursement Account. None of my spouse, dependents, or myself make contributions to an HSA or receive HSA contributions from anyone else.

**This election shall remain in force from year to year until revoked by me by checking this box:**

Please revoke this election. Must be revoked if ordering a Blue Priority Flex debit card.

## Direct Deposit Authorization (If this section is not marked, previous plan year election will be maintained)

**This agreement is:**  Same as last year (if checked, do not complete the rest of this section)  New  Change  Cancel

I have read and understand the information on the back of this form regarding direct deposit of reimbursements. I hereby authorize Wellmark Blue Cross and Blue Shield to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. **This election shall remain in force from year to year until revoked by me.**

Account Number \_\_\_\_\_ Transit ABA Routing # \_\_\_\_\_ Account Type:  Checking  Savings  
Name of Bank \_\_\_\_\_ Bank Phone \_\_\_\_\_

## Employee Authorization

I have read and understand the above agreement. I authorize my employer to redirect my salary according to this agreement and I will review my paycheck to verify that my employer has made appropriate withholding consistent with my election.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

This salary redirection agreement for my reimbursement account(s) and the Pre-Tax Premium Payments will continue until:

- I terminate employment with the employer listed above; or
- I have a qualifying status change (see Summary Plan Description) and I modify this agreement consistent with the change; or
- The end of the current plan year; or
- My employer terminates, suspends, or modifies this plan or the benefits under the plan

Return to: Benefit Plan Department, 5820 Westown Pkwy., West Des Moines, IA 50266

## Automatic Reimbursement Authorization

*This option allows eligible medical expenses that have been submitted to your 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 the eligible medical expenses will automatically be directed to your Medical Reimbursement Account for further consideration. This option is not available for Limited Purpose Medical Reimbursement Accounts (i.e., if you, your spouse, or dependents make contributions to an HSA or receive HSA contributions from anyone else). This option is also not available for participants who plan to order a Blue Priority Flex Debit Card.*

### Authorization

I am enrolled in a Medical Reimbursement Account administered by Wellmark Blue Cross and Blue Shield I hereby authorize Wellmark Blue Cross and Blue Shield to treat my claims as if they are made under both the medical plan and the Medical Reimbursement Account. Wellmark Blue Cross and Blue Shield will use the Medical Reimbursement Account to reimburse me for deductible, coinsurance, and copayment amounts eligible under IRC Section 213 (d). Contract limitations will need to be filed manually. Furthermore, I certify that:

- **I have not & will not order Blue Priority Flex debit card.**
- **I have no other insurance coverage.** No family members covered under my medical and/or dental contracts have other insurance which covers the charges referenced above. If other coverage is obtained during the plan year, I will notify my employer immediately and revoke this agreement.
- **Neither my spouse, my dependents, nor I make contributions to an HSA or receive HSA contributions from anyone else.**
- **Only legitimate claims will be submitted.** All claims submitted to the Wellmark Blue Cross and Blue Shield medical plan(s) will be for expenses that are reimbursable under the terms of the Medical Reimbursement Account. I will not submit paper claims to the Flexible Benefits Department if these charges will be processed by the medical plan(s), since these claims will automatically be forwarded to my Medical Reimbursement Account.

## Direct Deposit Authorization

- The **Transit ABA Routing #** includes all of the numbers between the colons. Be sure to include any zeroes at the beginning or end.
- The **Account Number** includes all of the numbers after the second colon and before the mark “#”. Be sure to include any zeroes at the beginning or end.

Mr. & Mrs. Ima Sample		2001-91
1234 Pretend Street		
Nonexistant, USA 00000		
PAY TO THE ORDER OF _____		_____ 20 _____
		\$ _____
		DOLLARS
NOTTA BANK Somewhere, USA		NON-NEGOTIABLE
⑆ 2001-91 ⑆ 123456789⑆ 0987654321⑆		

**Note:** If you are requesting direct deposit, you must attach a voided check for verification and reference. For any requests other than the beginning of your plan year, it will take two check cycles for the direct deposit authorization to be processed.