Wellmark

BluePriority Flex℠

Wellmark Blue Cross Blue Shield of Iowa
Wellmark Blue Cross Blue Shield of South Dakota

Independent Licensees of the Blue Cross and Blue Shield Association

Medical Reimbursement Account
Automatic Reimbursement Authorization Form

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 a Health Savings Account (HSA) or receive HSA contributions from anyone else).***

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 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.
- **I understand that previously processed claims will not be automatically reimbursed.** Claims incurred prior to the effective date of this authorization will not be reimbursed through this program and must be submitted manually.

This election shall remain in force until revoked by me.

_____ _____

Name *(Please Print)* Employer

_____ _____ / /

Social Security Number Signature/Date

To revoke an authorization for automatic reimbursement already in effect, check the box below and provide the information requested above.

☐ I wish to revoke my authorization for automatic reimbursement.

Complete, sign, and send this form to :
Wellmark Blue Cross and Blue Shield
Spending Accounts Office
PO Box 14314
Lexington, KY 40512-4314
Fax # (855) 299-4389
Email: wellfsa@wellmark.com
www.wellmark.com/flex