



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

**ENROLLMENT FORM**  
**Health Reimbursement Account**  
**with Debit Card Authorization**

**Employee Information**

Name		Social Security Number	
Home Address	City	State	Zip
Employer	Effective Date / /	Location/Class	Date of Birth / /

**Health Insurance Coverage**

Please indicate current level of coverage:

Single
  Family

Single + 1
  Other \_\_\_\_\_

**Blue Priority Flex Debit Card**

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

I wish to order an additional debit card for my spouse/dependent in the following name:  
 First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Please note that more extra cards can be ordered after the beginning of the plan year through [www.wellmark.com/flex](http://www.wellmark.com/flex) by selecting "View My Account", logging on and selecting the Flex Debit Card tab then the Extra Card tab. Each extra card must be ordered on separate days.

**Automatic Reimbursement Eligibility - not an option if ordering a Blue Priority Flex debit card**

One or more of me, my covered spouse, or dependents is/are covered by another health plan or program (including medicaid and medicare) and therefore will need to submit claims manually. I understand that I can only file claims that are covered benefits under my Blue Priority health plan.

None of myself, my covered spouse, or dependents are covered by another health plan or program and therefore my claims will be submitted automatically.

**Direct Deposit Eligibility**

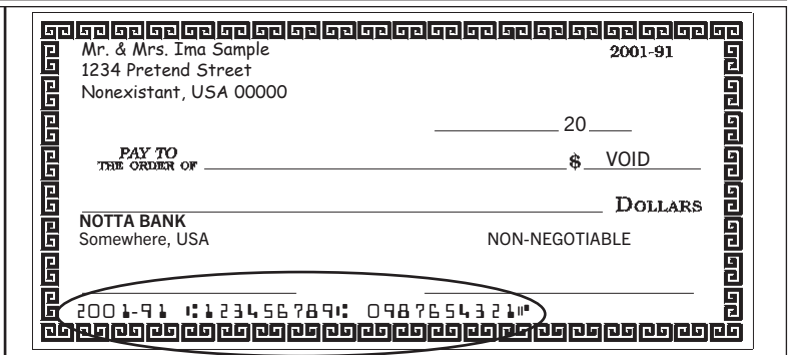
I hereby authorize Wellmark Blue Cross and Blue Shield to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This election shall remain in force until revoked by me.

Account Number \_\_\_\_\_ Transit ABA Routing # \_\_\_\_\_

Account Type:  Checking  Savings This agreement is:  New  Change  Cancel

Name of Bank \_\_\_\_\_ Bank Phone \_\_\_\_\_

- The **Transit ABA Routing #** includes all of the numbers between the colons in the middle of the number. Be sure to include any zeroes at the beginning or end.
- The **Account Number** includes all of the numbers after the second colon in the middle of the number. Be sure to include any zeroes at the beginning or end.



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.

**Employee Authorization**

By signing this form, I acknowledge that I have read and understand the form and that the information indicated above is true and correct to the best of my knowledge and that I am eligible for an HRA health plan.

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