



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

CHANGE FORM

Employee Reimbursement Account and Pre-Tax Premium Payments

Employee Information

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

As a participant in the Flexible Benefits Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status or other changes allowed under the Plan.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury. Please refer to your plan document for detailed information on status changes.

Change in Status

I certify that I have incurred the following change which allows me to change my election form:

Marriage, divorce, legal separation or annulment

Birth, adoption, or placement for adoption of a child

Death of my spouse and/or dependent

Dependent satisfies or ceases to satisfy eligibility requirements due to attainment of age, student status or other similar circumstances (please specify any other similar circumstances below)

Termination or commencement of my, my spouse's, and/or my dependent's employment

A change in my, my spouse's, or my dependent's employment status with the consequence of becoming or ceasing to be eligible under our respective employer's flexible benefit plan (e.g., if the plan only covers full-time employees, switching from part-time to full-time (or vice versa) constitutes a change in employment status)

I, my spouse, or dependent have commenced or concluded an unpaid leave of absence

A change in worksite for me, my spouse, or dependent (if eligibility or dependent care expenses are affected)

A change in place of residence for me, my spouse, or dependent (if eligibility or dependent care expenses are affected)

I, my spouse, or dependent became eligible to open a Health Savings Account (HSA) and will make or receive contributions in an HSA (your Medical Reimbursement Account will switch from a General Purpose Account to a Limited Purpose Account as of the effective date; you may not change your Medical Reimbursement election amount unless another change in status also applies)

Other _____

Mid-year Blue Priority Flex Debit Card Change

Terminate my Blue Priority Flex Debit card and DO NOT reinstate my automatic claim rollover option, if applicable.

Terminate my Blue Priority Flex Debit card and reinstate my automatic claim rollover option. I am responsible for ensuring no duplicate claims are reimbursed from my flex account subsequent to this change being implemented. I have submitted my debit card(s) to my employer.

Order a Blue Priority Flex Debit Card in my name and terminate my automatic claim rollover option, if applicable. I will not use my debit card for payment of claims already reimbursed from my flex account through automatic claim rollover. I would also like an extra card for my spouse/dependent in the following name:
First _____ MI _____ Last _____

Mid-year Reimbursement Account Election Change (if applicable)

Please change or cancel my salary redirection election as noted below:

Cancel my Medical Reimbursement Account for the rest of the year Year to date deductions \$ _____

Cancel my Dependent Care Reimbursement Account for the rest of the year Year to date deductions \$ _____

• **Medical Reimbursement Account Change** \$ _____ x _____ + _____ = \$ _____
(New Per Pay) (Pays Left/Year) (YTD Deductions) (New Plan Year 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. You may not switch from a Limited Purpose Account to a General Purpose Account during the year. If you switch from a General Purpose Account to a Limited Purpose Account mid-year, for claims incurred after the account is converted, only vision and dental expenses can be reimbursed.

• **Dependent Care Reimbursement Account Change** \$ _____ x _____ + _____ = \$ _____
(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.)
(New Per Pay) (Pays Left/Year) (YTD Deductions) (New Plan Year Election)

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/or 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