



Wellmark BlueCross BlueShield of Iowa
Wellmark BlueCross BlueShield of South Dakota
Independent Licensees of the Blue Cross and Blue Shield Association

ENROLLMENT FORM Health Reimbursement Account

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 _____

Automatic Reimbursement Eligibility

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

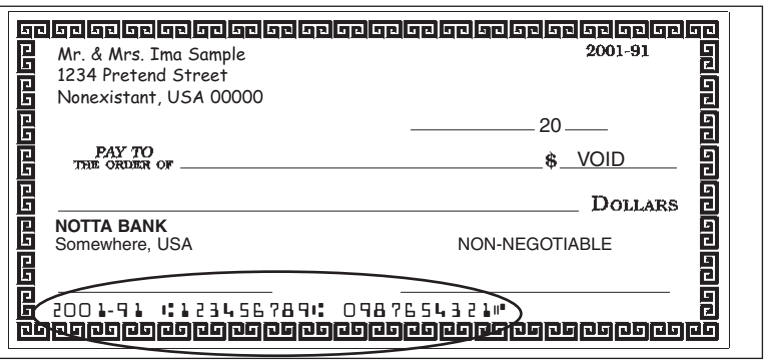
I hereby authorize Wellmark Blue Cross and Blue Shield to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This election shall remain in force until revoked by me.

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 ____/____/____