



Enrollment and Change Form

Large Group

- New Enrollment
- Status Change (includes: marriage, divorce, birth, adoption, death, change of employment by spouse)
- Open Enrollment
- Open Enrollment Cancel

Reference Information

This form is intended for use by members from Large Group Employer groups (51+ employees) for Health Reimbursement Arrangements or Flexible Spending Accounts offered by Blue Cross and Blue Shield of Montana (BCBSMT) preferred vendors: Your employer will inform you of which options are available to you.

- A **Health Reimbursement Arrangement (HRA)** is an account that is owned and funded by your employer. If offered, you can use these funds to pay for medical expenses as determined by your employer, usually including deductibles, coinsurance and copays. Due to IRS rules, you may not be eligible to enroll in an HRA if you are eligible for and contributing to an HSA, unless the HRA is a Limited Purpose HRA, which means it covers dental and vision expenses only or is post-deductible. Your employer will offer guidance on which HRA option to select if available.
- A **Flexible Spending Account (FSA)**, if offered by your employer, allows you to pay for qualified medical expenses on a pre-tax basis. You decide how much to contribute, up to the IRS max each year, and funds are deducted from your paycheck. During the year, you can only change the amount of your annual election if you have a qualifying life event. If you are enrolled in an HSA-qualified health plan and an HSA, you cannot enroll in an FSA unless your employer offers you the option of enrolling in a Limited Purpose FSA (LPFSA) which is used for qualified vision and dental expenses.

Employer/Employee Section

This enrollment form should be completed at the direction of your Employer and returned to your Employer.

| | | | |
|------------------------|---------------|----------------|--|
| EMPLOYER | GROUP NUMBER | ACCOUNT NUMBER | |
| EMPLOYEE NAME - LAST | FIRST | MIDDLE INITIAL | SEX: <input type="checkbox"/> M <input type="checkbox"/> F |
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | EFFECTIVE DATE | |
| HOME ADDRESS | CITY | STATE | ZIP |
| HOME PHONE | WORK PHONE | CELL PHONE | |

Consumer Directed Health Account Details

By electing one or more of the following, you are enrolling in a consumer directed health account through one of the BCBSMT preferred vendors. Once the vendor receives your enrollment, they will provide a welcome kit with additional details.

| | | | |
|---|-------------------------------|---|--------|
| Spending Account Election (Check all that apply) | | | |
| <input type="checkbox"/> Health Reimbursement Arrangement | | <input type="checkbox"/> Flexible Spending Account | |
| Health Reimbursement Arrangement Details (Fill out only if you have selected Health Reimbursement Account above) | | | |
| <input type="checkbox"/> HRA1 | <input type="checkbox"/> HRA2 | <input type="checkbox"/> HRA3 | |
| Flexible Spending Account Details (Fill out only if you have selected Flexible Spending Account above) | | | |
| Flexible Spending Account Plan Code (Check one box below) | | | |
| <input type="checkbox"/> FSA | | <input type="checkbox"/> Limited Purpose FSA (LPFSA)* | |
| Annual Election Amount** (Fill in dollar amount to the right, up to annual limit in whole dollars only.) | | | \$.00 |

*If you are enrolled in an HSA-qualified health plan and an HSA, your employer may offer the option of enrolling in an LPFSA.

**By completing this section, I understand this amount will be deducted from my pay throughout the plan year.

EMPLOYEE SIGNATURE _____ DATE ____/____/____