BlueCross BlueShield of Texas

Consumer Directed Health Accounts
(Health Reimbursement Arrangements, Flexible Spending Accounts)

Enrollment and Change Form **Middle Market and Large Group**

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

Reference Information

This form is intended for use by members from Middle Market and Large Group Employer groups (51+ employees) for Health Reimbursement Arrangements or Flexible Spending Accounts offered by Blue Cross and Blue Shield of Texas (BCBSTX) 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: ☐M ☐F
SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE	
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	

PRIMARY LANGUAGE	☐ CHECK HERE TO REQUEST A SPANISH FORM
DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? ☐ YES ☐ NO	IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED

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 BCBSTX preferred vendors. Once the vendor receives your enrollment, they will provide a welcome kit with additional details.

Spending Account Election (Check all that apply)		
☐ **Health Reimbursement Arrangement**	☐ **Flexible Spending Account**	
Health Reimbursement Arrangement Details (Fill out only if you have selected Health Reimbursement Account above)		
☐ **HRA1**	☐ **HRA2**	☐ **HRA3**
Flexible Spending Account Details (Fill out only if you have selected Flexible Spending Account above)		
Flexible Spending Account Plan Code (Check one box)	☐ **FSA**	☐ **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** _____/_____/_____

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