



An Independent Licensee of the Blue Cross Blue Shield Association

## PLAN CHANGE FORM

Please use this section to indicate any changes you wish to make to your plan for the upcoming year. If you have group contact changes, please fill out the [Group Contact Change Form](#).

<b>Group Information</b>	
Group Name: _____	Spending Account Group Number: _____

<b>Health Savings Account</b>			
<b>Plan Effective Date</b>	Start Date ____-____-____	End Date ____-____-____	
<b>HSA Plan Type Option</b>	Premium HSA <input type="checkbox"/>	Select HSA <input type="checkbox"/>	Value HSA <input type="checkbox"/>
<b>Participant Fees</b>	Employer Paid <input type="checkbox"/>	Employee Paid <input type="checkbox"/>	
<b>Reimbursement Options</b>	Please contact Health Spending Services at 877.293.7041 directly to adjust Crossover or Debit Card elections.		

If HSA is your only plan administered by Further, skip to the **Signature** box on page 3.

<b>Medical FSA</b>			
<b>Plan Effective Date</b>	Start Date ____-____-____	End Date ____-____-____	
<b>Minimum / Maximum Contribution Limits</b>	Minimum \$ _____	Maximum \$ _____ <i>(IRS Maximum is \$3200.00)</i>	
	Does the employer contribute to any account? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p><i>Note: According to IRS FSA regulations, employers can contribute up to \$550 to each employee without contributions from the employee. If the employer contributes more than \$550, the employee must contribute. The employer contribution cannot exceed the amount contributed by the employee.</i></p>			
<b>Grace Period</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Grace Period End Date</b>	____-____-____
<b>Runout Period</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Runout Period Length</b>	_____ months
<b>Account Rollover</b>	<input type="checkbox"/> Yes <i>Balance up to \$640 rolls over to subsequent plan year</i>  <input type="checkbox"/> No <i>No balance rolls over</i>		
<b>Reimbursement Options</b>	Please contact Health Spending Services at 877.293.7041 directly to adjust Crossover or Debit Card elections.		

Dependent Care FSA			
<b>Plan Effective Date</b>	Start Date ____ - ____ - ____	End Date ____ - ____ - ____	
<b>Minimum / Maximum Contribution Limits</b>	Minimum \$ _____	Maximum \$ _____ <i>(IRS Maximum is \$5,000)</i>	
	Does the employer contribute to any account? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Grace Period</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Grace Period End Date</b>	____ - ____ - ____
<b>Runout Period</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Runout Period Length</b>	_____ months

Health Reimbursement Account <small>Only for large groups using a customized vendor administration for HRA</small>		
<b>Plan Effective Date</b>	Start Date ____ - ____ - ____	End Date ____ - ____ - ____
<b>HRA Plan Type Option</b>	<input type="checkbox"/> ER Pays First	Annual Funding Amounts \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family
	<input type="checkbox"/> Shared Payment  Reimbursement Level <input type="checkbox"/> 80% of eligible charges <input type="checkbox"/> 50% of eligible charges <input type="checkbox"/> Other _____	Annual Funding Amounts \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family
	<input type="checkbox"/> EE Pays First	Annual Funding Amounts for EE Pay First \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family  Annual Threshold Amounts for EE Pay First \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family

<b>Health Reimbursement Account (continued)</b>			
<b>Mid-Year Enrollees / Contract Changes</b>	<input type="checkbox"/> 100% Funding regardless date of enrollment.		
	<input type="checkbox"/> Funding is prorated in monthly increments back to first of the month of enrollment		
	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"><input type="checkbox"/> Funding is a specific amount if enrollment occurs in final 6 months of plan year</td> <td style="width: 50%; vertical-align: top;"> <b>Annual Funding Amounts</b>            \$ _____ Employee            \$ _____ Employee &amp; Child            \$ _____ Employee &amp; Spouse            \$ _____ Employee &amp; Children            \$ _____ Family         </td> </tr> </table>	<input type="checkbox"/> Funding is a specific amount if enrollment occurs in final 6 months of plan year	<b>Annual Funding Amounts</b> \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family
<input type="checkbox"/> Funding is a specific amount if enrollment occurs in final 6 months of plan year	<b>Annual Funding Amounts</b> \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family		
<b>Account Balance Cap</b>	Balance Cap Limit: \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family		
<b>Runout Period</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;"><b>Runout Period Length</b></td> <td style="width: 100px;">_____ months</td> </tr> </table>	<b>Runout Period Length</b>	_____ months
<b>Runout Period Length</b>	_____ months		
<b>Account Rollover</b>	<input type="checkbox"/> Full Rollover		
	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"><input type="checkbox"/> Flat Dollar Limit</td> <td style="width: 50%; vertical-align: top;"> <b>Rollover Limit:</b>            \$ _____ Employee            \$ _____ Employee &amp; Child            \$ _____ Employee &amp; Spouse            \$ _____ Employee &amp; Children            \$ _____ Family         </td> </tr> </table>	<input type="checkbox"/> Flat Dollar Limit	<b>Rollover Limit:</b> \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family
	<input type="checkbox"/> Flat Dollar Limit	<b>Rollover Limit:</b> \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family	
	<input type="checkbox"/> Percentage Rollover	_____ %	
<input type="checkbox"/> No Rollover			
<b>Reimbursement Options</b>	Please contact Health Spending Services at 877.293.7041 directly to adjust Crossover or Debit Card elections.		

<b>Signature</b>
Signature: _____ Date: _____

Questions? **Call Health Spending Services at 877.293.7041.**

**Send via secured email only:**  
 CapitalBlueCross.documents@HelloFurther.com