FURTHER℠

GROUP CHANGE FORM

Please fill out this form for mid-plan year changes and return in its entirety to Further 2 weeks in advance of the change effective date. If you have questions on how to complete the form, please call our Group Leader Line at 1-888-460-4013 or our Agent Service Line at 1-888-460-4015.

Group Information (Required)

Group Name: _____ Further Group # _____

Health Plan: _____

Health Plan Change and Effective Date

New Health Plan: _____ Effective Date: _____

Optional Features

The crossover and pay-the-provider election applies across all medical spending accounts (i.e. Medical FSA, HRA, or HSA).

Medical Crossover (must have health plan with BCBSMN, BCBS of Kansas, CCStpa or BlueLinkTpa)

- ☐ New participants are auto-enrolled in medical crossover. (Existing participant elections will not be changed.)
- ☐ All participants are auto-enrolled in medical crossover. (If this is selected, ALL participants will be enrolled in crossover as of the date this change is processed. Any participants who have previously declined crossover will need to decline crossover again.)
- ☐ Participants elect medical crossover. (highest participant fees apply)
- ☐ Do not offer medical crossover. (highest participant fees apply)

Delta Dental of Minnesota Crossover (Must have dental coverage through Delta Dental of MN)

- ☐ New participants are auto-enrolled in dental crossover. (Existing participant elections will not be changed.)
- ☐ All participants are auto-enrolled in dental crossover. (If this is selected, ALL participants will be enrolled in crossover as of the date this change is processed. Any participants who have previously declined crossover will need to decline crossover again.)
- ☐ Participants elect dental crossover.
- ☐ Do not offer dental crossover.

Pay-the-provider (must have health plan with BCBSMN and medical crossover)

- ☐ All new participants are auto-enrolled in pay-the-provider. Additional fee applies to all participants regardless of their pay-the-provider election. Must also select one of the auto-enroll options in medical crossover. (Participants may opt out of pay-the-provider by completing the pay-the-provider Election Form, F9089.)*
- ☐ Offer pay-the-provider to participants. Additional fee applies to all participants regardless of their pay-theprovider election. Participants may elect pay-the-provider by completing the pay-the-provider Election Form, F9089.)*
- ☐ Do not offer pay-the-provider.

* If you chose 'All new participants are auto-enrolled in pay-the-provider' and you have an HSA, your HSA election will be defaulted to 'Offer pay-the-provider to participants.'

Effective Date of change: _____

Debit Card Option

Debit Card Option

- Changing your current debit card option may require current cards to be turned off and new cards will be issued.
- If both medical crossover and debit cards are offered, participants can choose one or the other, not both.
- Select just one:
  - ☐ **New** participants will be offered a debit card. Only new participants are issued a debit card and existing participants elections remain the same.
  - ☐ **New** participants and existing participants not enrolled in crossover will be issued a debit card automatically. Existing participants in crossover will remain in crossover.
  - ☐ **All** participants will be offered a debit card. New participants will be issued a debit card and existing participants will be opted out of crossover and issued a debit card.

Effective Date of change: _____

Administrative Fees (HSA Only)

The crossover and pay-the-provider election applies across all medical spending accounts (i.e. Medical FSA, HRA, or HSA).

Participant Fees (if your group offers another medical account with Further, the fees must be employer paid on a monthly basis.)

☐ Employer Paid - Indicate billing frequency:

- ☐ monthly
- ☐ annually (recommended for 10 or less participants)

☐ Participant Paid - (Billed monthly and taken from participant's account balance.)

Group Signature

It is agreed that necessary information concerning employees or employees and their dependents participating in or subsequent to the effective date of the Plan and employees whose participation is to be changed or discontinued shall be furnished to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS FORM. THE INFORMATION PROVIDED ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Authorized Signature: _____ Date: _____

Print Name: _____ Title: _____

Questions? Call Group Leader Services at 1-888-460-4013.

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