FURTHER℠

VEBA ACCOUNT OPTION FORM

Member Information

Name: _____ **Spending Account ID or SSN:** _____

Employer Name: _____

Account Options (choose one)

☐ I do not wish to have my VEBA account accessed for claims processed by Further.

☐ I wish to have a post-deductible VEBA which will provide reimbursement for permitted benefits such as vision and dental until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses are eligible for reimbursement.

☐ I wish to have a limited-purpose VEBA which is limited to expenses for permitted benefits such as vision and dental care both before and after the health plan deductible is met.

☐ I authorize Further to access my VEBA account for the reimbursement of claims processed by Further.

Signature

I understand that Further will process claims in accordance to my selection above.

Signature of Account Holder: _____ **Signature Date:** _____

Save time: submit this information online. Questions? Call Member Services at 1-800-859-2144.

Submit online:	**Send via secured email only:**	**Fax to:**	**Mail to:**
Log into your account at hellofurther.com	further.documents @hellofurther.com	866-231-0214	P.O. Box 64193 St. Paul, MN 55164-0193