BlueCross BlueShield of Montana

Consumer Directed Health Accounts
(Flexible Spending Accounts)

Enrollment and Change Form

Small 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 Small Group Employer groups (2-50 employees) for 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 **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	

Consumer Directed Health Account Details

By completing the Flexible Spending Account election below, you are enrolling in a Flexible Spending Account through one of the BCBSMT preferred vendors. Once the vendor receives your enrollment, they will provide a welcome kit with additional details.

Flexible Spending Account Election	
Flexible Spending Account Plan Code (Check one box below)	
☐ **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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