Blue Cross Blue Shield of Wyoming
FLEXSHARE BENEFITS
HEALTH REIMBURSEMENT ARRANGEMENT

EMPLOYER: _____

EMPLOYEE: _____ DATE OF BIRTH:_____

MAILING ADDRESS:_____

CITY, STATE, ZIP:_____

EMAIL ADDRESS: _____PHONE NUMBER: _____

SOCIAL SECURITY #:_____ **Effective date:_____**

I hereby elect my benefit election for the HRA plan.

The current plan year will be in effect from_____through_____.

This election will be in effect until revoked by the employee or employer.

___**XX**__ Health Reimbursement Arrangement **$**_____

AutoPay Authorization

This authorizes FlexShare Benefits to electronic transfer from your Blue Cross Blue Shield of Wyoming group health insurance to your Health Reimbursement Account (HRA). Weekly, claims will be extracted from BCBS Wyoming claims processing system, uploaded to FlexShare Benefits processing system; eligible claims will AutoPay from your HRA **without submitting reimbursement forms** and documentation.

☐ By checking this box, you are authorizing FlexShare Benefits to AutoPay your claims.

_____ _____

Signature of Employee Date