

SelectAccountSM

Pay-the-provider Option For reimbursement of health care expenses

By authorizing this feature, SelectAccount, your account administrator will reimburse the provider directly for costs that count toward your health care deductible and/or coinsurance as indicated on your health plan Explanation of Benefits. This option is available for claims where:

- The provider is a participating provider with Blue Cross and Blue Shield.
- You are enrolled in medical crossover and claims are reimbursed through the medical crossover feature offered by SelectAccount.
- The member has an account balance.

If your health care claim is adjusted after the claim has processed against your spending account, there is a risk that you may receive excess payment from your account. If this occurs, you will be responsible for contacting the provider and requesting the overpayment. The overpayment should be sent to SelectAccount to credit your account.

To decline pay-the-provider

NO — By signing this form, I am indicating that I do not wish to be enrolled in the pay-the-provider feature for my spending account(s).

To choose pay-the-provider

YES — By signing this form, I am indicating that I wish to enroll in the pay-the-provider feature for my spending account(s).

Please note: Once you have authorized this option, there is no need to re-authorize in subsequent plan years unless you choose not to participate in the pay-the-provider feature. You may change your election at any time during the plan year by submitting a new form, choosing the "decline" option above.

By signing this form, I certify that such expenses will not be eligible for benefit payment by any other insurance carrier and that such expenses will not be manually submitted by me to this or any other health care reimbursement account, including a flexible spending account. If I manually submit claims to SelectAccount, I understand that SelectAccount will not reimburse the provider from my account. I also understand that SelectAccount will not recoup overpayments made to the provider.

Health Plan ID #: _____ SelectAccount ID or SSN: _____
(From your health plan ID card)

Employee Name: _____ Employee Signature: _____
(Please print)

Employer Name: _____ Date: _____

Your request will be effective within 10 business days from receipt. If claims are processed prior to the effective date of the pay-the-provider option, claims will be reimbursed to you and you will be responsible to pay your provider.

Please return your completed form to:

SelectAccount
P. O. Box 64193
St. Paul, MN 55164-0193
Fax (651) 662-7247 or 1-866-231-0214