SelectAccount℠

VEBA ACCOUNT OPTION FORM

Member Information

Name: _____ **SelectAccount ID or SSN:** _____

Employer Name: _____

Account Options (choose one)

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

☐ 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 SelectAccount to access my VEBA account for the reimbursement of claims processed by SelectAccount.

Signature

I understand that SelectAccount 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 (651) 662-5065 or 1-800-859-2144.

Submit online:	**Send via secured email only:**	**Fax to:**	**Mail to:**
Log into your account at www.SelectAccount.com	SelectAccount.documents @SelectAccount.com	651-662-7247 866-231-0214	P.O. Box 64193 St. Paul, MN 55164-0193