

Medical Crossover Election Form

Authorizing crossover eliminates the need to file a claim with SelectAccount, your account administrator. With Crossover, costs that count toward your health care deductible and/or coinsurance as indicated on your health plan Explanation of Benefits, plus out-of-pocket expenses for prescription drug claims, will be electronically transferred from your insurance carrier to SelectAccount. These claims will then be processed and you will be reimbursed according to your available balance and your employer's claims processing schedule, if applicable.

- **If you are part of an employee group, Medical crossover is only available if your group chose to offer medical crossover to it's employees.**
- **If you have secondary health coverage (private or medicare) you CANNOT choose Crossover, since your patient responsibility amount should be submitted to the secondary insurance company before your reimbursement account.**
- **If your health care and/or prescription drug claim is adjusted after the crossover claim has processed against your reimbursement account, you may receive excess payment from your account. If this occurs, you will be responsible for returning the overpayment so your account is credited the overpayment.**
- **If you are enrolled in a an employer group plan who chooses Automatic Crossover, you will be automatically enrolled in Crossover unless you choose not to participate by declining Crossover below. Check your plan materials carefully and/or discuss with your group leader.**

To decline Crossover

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

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

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

Employer Name: _____ Date: _____

To choose Crossover

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

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

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

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 for expenses that will automatically be processed through Crossover, I understand that SelectAccount may remove Crossover from my account. I also understand that if other insurance coverage is discovered that could cover these expenses, my claims will not "crossover" and I will need to submit a manual claim.

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

Employer Name: (if applicable) _____ Date: _____

Your request will be effective within 10 business days from receipt. You can review the status of this request on our website at www.selectaccount.com.

Please return your completed form to:

SelectAccount
P. O. Box 64193

St. Paul, MN 55164-0193