Capital

An Independent Licensee of the Blue Cross Blue Shield Association

GROUP COPAY FORM

GROUP INFORMATION

Group Name: _____ Spending Account Group Number: _____

COPAY INFORMATION

Please indicate the copay amounts you would like to establish for your plan participants below. The copay amounts provided, and exact multiples thereof (up to five times the dollar amount of each copayment), will auto-substantiate when the debit card is used. Documentation will not be required for reimbursement.

Medical	Dental	Vision	RX
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$
$	$	$	$

SIGNATURE

Effective Date of Change: _____

Group Contact Signature: _____

F11264 (06/21)