Capital

An Independent Licensee of the Blue Cross Blue Shield Association

DISBAND NOTICE

Group Name: _____ **Spending Account Group Number:** _____

It has been our pleasure to serve as your personal spending account administrator. We are sorry you will be terminating one or all the products you have with us. The following information is required to disband your group or product. This information will ensure claims are processed correctly and will provide you with the information your employees or new administrator will need going forward.

Why are you leaving? (Check all that apply)

- ☐ Participation is too low
- ☐ Changing health plans
- ☐ Merger or acquisition (Company Name):_____
- ☐ Pricing of products
- ☐ Service (please describe): _____
- ☐ Capital Blue Cross does not offer my desired product or service (please describe):_____
- ☐ Other: _____

Are you moving to another administrator? ☐Yes ☐No

If Yes, please note your new Administrator's name:_____

Would you need a bulk transfer of HSA funds? ☐Yes ☐No

Disband and Runout Information

- **Disband Date:** defined as the last day you would expect an employee to incur expense for reimbursement while active under group plan. The date must be an end of month date.
- **Runout Months:** defined as the time allowed after disband for claims to be received by Capital Blue Cross. Runout may incur additional fees billed by calculating number of participants with account balance x monthly fee x number of runout months.

Which product(s) will you be disbanding?

- ☐ **All Products**
  Disband Date (if the same date for all products): _____
  Runout months (if applicable and the same for all products): _____
- ☐ **One/Some Products**
  If you are disbanding some products and not others or if you have different disband or runout months based on product, please indicate on second page of form below.

Indicate Disband Dates and Runout Months

Plan Type	Disband Dates	Runout Months
Health Savings Account (HSA):	_____	
Medical Flexible Spending Account (FSA):	_____	Runout Months: _____
Dependent Care Spending Account (DCAP):	_____	Runout Months: _____
Health Reimbursement Account (HRA):	_____	Runout Months: _____

Claims Appeals

Note: This section is only for disbanded FSA or HRA products. Please skip this session if you are you are not disbanding FSA or HRA products.

Members have the right to appeal claim denials 180 days after a denied claim was processed.

Select one option:

☐ New account administrator will process appeals/adjustments for members.

☐ Capital Blue Cross will process appeals/adjustments for members.

Signature

Claims billed are valid through processing date by Capital Blue Cross.

I have read and understand the choices within this form and the information is, to the best of my knowledge, accurate.

Group Contact Name (please print): _____

Group Contact Signature: _____

Group Contact Email Address: _____

Date: _____

Questions? **Call Group Leader Services at 877.293.7041.**

Send via secured email only:
CapitalBlueCross.Sales@HelloFurther.com

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