



VEBA ACCOUNT OPTION FORM

Member Information	
Name: _____	Spending Account ID or SSN: _____
Employer Name: _____	
Account Options (choose one)	
<input type="checkbox"/> I do not wish to have my VEBA account accessed for claims processed by Further.	
<input type="checkbox"/> 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.	
<input type="checkbox"/> 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.	
<input type="checkbox"/> I authorize Further to access my VEBA account for the reimbursement of claims processed by Further.	
Signature	
I understand that Further 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 1-800-859-2144.

Submit online:
Log into your account at
hellofurther.com

Send via secured email only:
further.documents@hellofurther.com

Fax to:
866-231-0214

Mail to:
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El Paso, TX 79998-2814