SelectAccount®

VEBA ENROLLMENT FORM

Complete and return to your employer

Group Information

Group Name: _____ **SelectAccount Group Number**:_____

Location Name (if applicable):_____

Employee Information

SSN#:_____ **Primary Phone**:_____

Last Name:_____ **First Name**:_____**Middle Initial**:_____

Street Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Email Address:_____ **Date of Birth**:_____

Account Information

VEBA:

Effective Date: _____ (to be provided by Group Contact)

Health Plan Coverage:

☐ **VEBA Active**

☐ **VEBA Post**
(Effective date is the last day of employment)

☐ **VEBA Wellness**

☐ **VEBA Retiree**
(Account is pre-funded and funds frozen)

Dependent on Health Plan

☐ **Single**

Does this dependent have Medicare?

- ☐ **Yes**. Medicare Effective Date: _____
- ☐ **No**

☐ **Family Coverage** (If checked fill out the VEBA dependent form)

Employee Signature

Signature: _____ **Date**: _____

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