

Enclosed forms: ***New Subscriber Enrollment form (Page 2)***
Change of Status form (Page 6)

Blue Cross Physician Choice/BCN Primary Care Physician Selection form (Page 4)
Health Savings and Flexible Spending Account Options form (Page 8)

Please read the following information before completing the attached forms. The information on these forms and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan.

I am applying for health care coverage with Blue Cross Blue Shield of Michigan or Blue Care Network, or I am modifying existing coverage for me or my dependents. Coverage begins on the date determined by Blue Cross or BCN. When Blue Cross or BCN accepts my application or changes, my covered dependents and I are bound by the terms of the Blue Cross or BCN certificates, riders, other coverage documents, policies and these forms. I understand that submitting false or misleading information or omitting material information on these forms may result in rejection of my changes or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by Blue Cross or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. My employer may forward any agreed deductions for coverage from my wages. I am responsible for notifying my employer or association of changes in my status or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements or death of someone covered under the policy. I authorize Blue Cross or BCN or my primary care physician to obtain the medical records relating to me and my enrolled family members needed to coordinate our medical care, administer my Blue Cross or BCN coverage and for other purposes necessary for Blue Cross or BCN to fulfill its contractual and statutory obligations.

Health Insurance Portability and Accountability Act: If I lose my eligibility for coverage, I may be entitled to special enrollment rights under HIPAA. Blue Cross or BCN reserves the right to request written verification of the date of the event and reason for loss of eligibility from my previous group or carrier. HIPAA special enrollment rights do not pre-empt a new-hire waiting period, which must first be satisfied. Termination of employment may qualify for special enrollment rights, but voluntary terminations of other health care coverage do not.

Release of health care information: I acknowledge that Blue Cross or BCN requires me to provide my Social Security number. In applying for coverage, I and my enrolled dependents agree to permit health care providers and others to release "protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996) to Blue Cross or BCN for administering our coverage. Upon my request, Blue Cross or BCN will tell me where the information was sent. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize Blue Cross or BCN to provide claim information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

Group representative information: The group confirms that the status change requested complies with and is permitted under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

I and my enrolled family members agree that all our medical services may be performed, prescribed, directed or authorized by our designated BCN primary care physician except in the case of an immediate and unforeseen medical emergency when the time needed to contact our primary care physician may mean permanent damage to our health. Unauthorized services that are not an emergency as described above, received from non-BCN providers, will not be covered.

I agree to assign to BCN the right to recover from any person or organization the cost of hospital, medical and prescription services delivered by or paid for by BCN as a result of accident or disease, including injuries or disease claimed under workers' compensation laws or acts, whether by redemption award, voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release any information needed to determine benefits coverage to the Centers for Medicare and Medicaid Services, any insurance company or any HMO and their agents. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to BCN on my behalf for any services that BCN provides to me and my enrolled family members.

Send completed forms to:

(For Blue Cross Blue Shield of Michigan)
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610I
P.O. Box 2260
Detroit, MI 48226 Fax: 1-866-900-2619

(For Blue Care Network)
Blue Care Network
Membership and Billing – M.C. C300
P.O. Box 5043
Southfield, MI 48086

Fax: 1-877-218-1466



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association



New Subscriber Enrollment
(See Page 3 for instructions)

Blue Cross Blue Shield of Michigan

Blue Care Network

(Also complete Page 4 for Physician Choice or primary care physician selection)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature
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Subscriber information

Date	<input type="checkbox"/> Non U.S. citizen	Social Security/TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber birth date	Home street address			City	State	ZIP code	
County	Country – if other than USA	Primary telephone number	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary telephone number	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Email	

List all persons to be covered:

	Legal last name	Legal first name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Non U.S. citizen <input type="checkbox"/>	Social Security/TIN number (required)	*Relationship code (see instructions for codes)
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 1				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 2				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 3				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 4				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		

If the permanent address of the spouse or dependent is different from the address above, please complete the information below:

Spouse or dependent (full name)	Street address	City	State	ZIP code
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Coordination of benefits information

Do you, your spouse or dependents have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," complete below:	<input type="checkbox"/> Check here if this applies to all members on the contract.		
Person covered (full name)	Employer or group name	Policy number	Carrier	Address

I have read and understand the conditions of this form.

Subscriber signature:

Date:

Health savings, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

FSA HRA HSA HSA Opt out

Blue Cross product indicator code Add Change Cancel

Goal amount: _____

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Date of hire	Effective date
Check coverage if applicable: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy	Check type of enrollment: <input type="checkbox"/> New <input type="checkbox"/> Full time <input type="checkbox"/> Rehire <input type="checkbox"/> Part time	<input type="checkbox"/> Transfer <input type="checkbox"/> Return from layoff Old group division/subgroup _____	<input type="checkbox"/> Loss of eligibility (prior coverage) New group division/subgroup _____	<input type="checkbox"/> Salary <input type="checkbox"/> Retiree <input type="checkbox"/> Hourly <input type="checkbox"/> Open enrollment	<input type="checkbox"/> Surviving spouse	Average hours worked per week (required): _____ Job title (required) _____
COBRA enrollment Check reason:	<input type="checkbox"/> Termination <input type="checkbox"/> Layoff	<input type="checkbox"/> Reduction of hours <input type="checkbox"/> Loss of dependent status	<input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Deceased subscriber	Previous contract number	Original qualifying date	
Loss of eligibility (prior coverage) <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," complete:	Carrier's name (including Blue Cross and BCN)	Contract holder name	Policy number	Termination date	
Are any members listed enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," check reason category <input type="checkbox"/> Over 65 and working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	Medicare ID:	Medicare A effective date	Medicare B effective date	Medicare Part D effective date	
<input type="checkbox"/> Medicare primary <input type="checkbox"/> Blue Cross or BCN primary	<input type="checkbox"/> Subscriber <input type="checkbox"/> Dependent name:	<input type="checkbox"/> Spouse				

Instructions for completing *New Subscriber Enrollment* form on Page 2

- Indicate if enrolling in Blue Cross or Blue Care Network. If enrolling with Blue Cross Physician Choice or with BCN, you are also required to complete the *Blue Cross Physician Choice/BCN Primary Care Physician* form on Page 4 to designate your primary care physician.
- Enter Blue Cross group and division number (for example, suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the "Employer Signature" section.

Subscriber information:

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter home address beginning with street address, city, state and ZIP code. Enter email address to receive health and wellness information.
- Enter county name for home address and country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons to be enrolled. Enter names on appropriate line – Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if you have more than four dependents.
- Enter last name, middle initial, male or female and date of birth. If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx). Enter the relationship code of the member (see below).

Relationship codes:

N – Child (by birth or adoption)	A – Child adoption in process**	C – Court order coverage (QMCSO)**	SP – Spouse
S – Stepchild	L – Legal guardianship**	D – Disabled child***	DP – Domestic partner
P – Principal support (BCN only)*	SD – Sponsored dependent*	M – Medicare	

* = Attached documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate "Yes" or "No" if you, your spouse or dependent have other health care coverage. If "Yes," list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings, health reimbursement and flexible spending account options:

- Check all applicable options. Blue Cross only: See Page 8 for four-digit product indicator code. Return to Page 2 or 6 and enter the four-digit Blue Cross product indicator code.

Employer/group use only:

- Enter employer or group name and employee reference ID or department number, if applicable. Enter benefit code (service code, package code). For the plan code field, enter "710" to represent Blue Cross Blue Shield of Michigan. Enter date of hire and effective date.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrolment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA, check the reason for COBRA. Indicate the previous contract number and the original qualifying date. If transfer, please indicate the old group/division/subgroup and new group division/subgroup numbers.
- For loss of eligibility (prior coverage), indicate "Yes" or "No." If "Yes," please indicate the carrier name, contract holder name, policy number and termination date. If coverage is lost from an insurance carrier other than Blue Cross or BCN, then a letter of credible coverage is required.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If "Yes," check the reason category to explain the member's enrollment in Medicare. Indicate if Medicare is primary or if Blue Cross or BC is primary and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation for enrollment.



Blue Cross Physician Choice PPO/BCN Primary Care Physician Selection (see Page 5 for instructions)

<input type="checkbox"/> Non U.S. citizen	Subscriber Social Security number/TIN (required)	Blue Cross/BCN group number	Blue Cross division/BCN subgroup number	BCN class number
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If you are enrolling in Blue Cross Blue Shield of Michigan Physician Choice PPO or Blue Care Network, you need to select a primary care physician for you and each person on your contract. List your selections on this form.

You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a primary care physician. You also need to fill out this form if you are already enrolled in Blue Cross or BCN and have decided to change your primary care physician.

Need information about available primary care physicians?

Our website, bcbsm.com/find-a-doctor, provides the most current information on Blue Cross and BCN-affiliated primary care physicians. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, city or hospital group.

Member information						
	Member's last name, first name	Physician last name, first name	Physician's NPI#	Physician address	If change PCPs, list reason	Seen in the last 12 months?
Subscriber						<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 1						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 2						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 3						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 4						<input type="checkbox"/> Yes <input type="checkbox"/> No
Group/Employer's name:					Effective date of change:	
I have read and understand the conditions of this form.		Subscriber signature			Date:	

Return this form to start your health care partnership

We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

For Blue Cross Blue Shield of Michigan:

Fax your complete form to 1-866-900-2619
Or mail to:
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 6101
P.O. Box 2260
Detroit, MI 48226

For Blue Care Network:

Fax your complete form to 1-877-218-1466
Or mail to:
Blue Care Network
Membership and Billing – M.C. C300
P.O. Box 5043
Southfield, MI 48086-5043

All changes become effective two business days after we receive this form – unless you request a later effective date.

You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs. You may request to change your primary care physician effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

Instructions for completing the *Blue Cross Physician Choice/BCN Primary Care Physician Selection* form on Page 4

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen, enter a taxpayer identification number in the Social Security number field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter each member's last and first name, physician's last name and first name, physician's NPI number, physician's address and the reason for changing your primary care physician, if applicable. Indicate if the primary care physician has been seen in the last 12 months. You can find the physician's NPI number when searching for a doctor on **bcbsm.com/find-a-doctor**.
- Enter the employer's name and the date you changed to this physician.
- In the signature section, sign your full name and enter the date that you signed the form.

Note: Submit the *Blue Cross Physician Choice/BCN Primary Care Physician* form with your *New Subscriber Enrollment* form when enrolling with Blue Cross or BCN.

Change of Status

Blue Cross Blue Shield of Michigan Blue Care Network (see instructions on Page 7)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date
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Subscriber information (*Indicate changes only)

<input type="checkbox"/> Non U.S. citizen	Social Security/TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.*	Date of birth*	Marital status* <input type="checkbox"/> S <input type="checkbox"/> M	Gender* <input type="checkbox"/> M <input type="checkbox"/> F
New home street address*			City*	State*	ZIP code*	Email*	
County*	Country – if other than USA*		New primary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell			New secondary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	

List all persons to be added or deleted:

	Legal last name	Legal first name	M.	Gender	Date of birth	Non U.S. citizen	Social Security/TIN number (required)	*Relationship code (see instructions for codes)
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 1 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 2 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 3 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		
Dep. 4 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>		

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or dependent (full name)	Home street address	City	State	ZIP code
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Coordination of benefits information

Do you, your spouse or dependents have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes," complete below:		<input type="checkbox"/> Check here if this applies to all members on the contract.	
Person covered (full name)	Employer or group name	Policy number	Carrier	Address	

I have read and understand the conditions of this form.	Subscriber signature:	Date:
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Health savings, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

<input type="checkbox"/> FSA <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> HSA Opt out	Blue Cross product indicator code	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Goal amount:
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Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code
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Check reason for change below: <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of eligibility (prior coverage) <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Dependents <input type="checkbox"/> Name change <input type="checkbox"/> Open enrollment <input type="checkbox"/> Address change <input type="checkbox"/> Transfer old group division/subgroup _____ New group division/subgroup _____ Date of event: _____ Effective date: _____	Check type of cancellation and reason below. Type: <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents Reason: <input type="checkbox"/> COBRA <input type="checkbox"/> Death <input type="checkbox"/> Left employment <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent over age <input type="checkbox"/> Other <input type="checkbox"/> Retired <input type="checkbox"/> Other insurance <input type="checkbox"/> Last date of coverage: _____
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Loss of eligibility (prior coverage)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," complete below:
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Carrier's name (including Blue Cross and BCN)	Contract holder name	Policy number	Termination date
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Are any members listed enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes," check reason category <input type="checkbox"/> Over 65 and working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	
<input type="checkbox"/> Medicare primary	<input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse	Medicare A effective date _____	Medicare B effective date _____
<input type="checkbox"/> Blue Cross or BCN primary	Dependent name: _____	Medicare Part D effective date _____	Medicare ID: _____

Instructions for completing *Change of Status* form on Page 6

- Indicate if enrolling in Blue Cross or Blue Care Network. If enrolling with Blue Cross Physician Choice or with BCN, you are also required to complete the *Blue Cross Physician Choice/BCN Primary Care Physician* form on Page 4 to designate your primary care physician.
- Enter Blue Cross group and division number (for example, suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the "Employer Signature" section.

Subscriber information:

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter new home address beginning with street address, city, state and ZIP code. Enter email address to receive health and wellness information.
- Enter new county name for home address and country name (if other than USA). Enter new primary phone, if changing, and indicate if home, work or cell. Enter new secondary phone number and indicate if home, work or cell.
- List all persons to be added or deleted. Enter name(s) on appropriate line – Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if all your dependents do not fit on this form.
- Enter last name, middle initial, male or female and date of birth. If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx). Enter the relationship code of the member (see below).

Relationship codes:

N – Child (by birth or adoption)	A – Child adoption in process**	C – Court order coverage (QMCSO)**	SP – Spouse
S – Stepchild	L – Legal guardianship**	D – Disabled child***	DP – Domestic partner
P – Principal support (BCN only)*	SD – Sponsored dependent*	M – Medicare	

* = Attached documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate "Yes" or "No" if you, your spouse or dependent have other health care coverage. If "Yes," list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings, health reimbursement and flexible spending account options:

- Check all applicable options. Blue Cross only: See Page 8 for four-digit product indicator code. Return to Page 2 or 6 and enter the four-digit Blue Cross product indicator code.

Employer/group use only:

- Enter employer or group name and employee reference ID or department number, if applicable. Enter benefit code (service code, package code). For the plan code field, enter "710" to represent Blue Cross Blue Shield of Michigan. Enter date of hire and effective date.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrolment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA, check the reason for COBRA. Indicate the previous contract number and the original qualifying date. If transfer, please indicate the old group/division/subgroup and new group division/subgroup numbers.
- For loss of eligibility (prior coverage), indicate "Yes" or "No." If "Yes," please indicate the carrier name, contract holder name, policy number and termination date. If coverage is lost from an insurance carrier other than Blue Cross or BCN, then a letter of credible coverage is required.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If "Yes," check the reason category to explain the member's enrollment in Medicare. Indicate if Medicare is primary or if Blue Cross or BC is primary and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation for enrollment.

Blue Cross Blue Shield of Michigan Health Savings and Flexible Spending Account Options

If you are enrolling in a health savings and flexible spending account, please indicate below which options you are selecting by checking all appropriate boxes. Record your selections and the corresponding product indicator code on Page 2 for new enrollments or on Page 6 for a change of status in the “Health savings and flexible spending account options” section of the form. If you have selected as FSA product, please indicate your designated goal amount on Page 2 or Page 6 of the form.

Product selections

Product selected (Check box)	Product name	Product indicator code
<input type="checkbox"/>	Health Savings Account (HSA)	1000
<input type="checkbox"/>	HSA with limited purpose Flexible Spending Account (FSA)	1070
<input type="checkbox"/>	HSA with dependent care FSA	1004
<input type="checkbox"/>	HSA with limited purpose FSA and dependent care FSA	1074
<input type="checkbox"/>	Health Reimbursement Arrangement (HRA)	0100
<input type="checkbox"/>	HRA with limited purpose FSA	0170
<input type="checkbox"/>	HRA with dependent care FSA	0104
<input type="checkbox"/>	HRA with limited purpose FSA and dependent care FSA	0174
<input type="checkbox"/>	HRA with FSA	0110
<input type="checkbox"/>	HRA with FSA and dependent care FSA	0114
<input type="checkbox"/>	Health care FSA	0010
<input type="checkbox"/>	Dependent care FSA	0004
<input type="checkbox"/>	Health care FSA and dependent care FSA	0014
<input type="checkbox"/>	Limited Purpose FSA	0070

