

HealthSecure HRA® Employer Account Investment

The Variable Annuity
Life Insurance Company (VALIC)
Houston, Texas



Submit completed form through our Secure Message Center: (1) Log in at **HealthSecureHRA.com**; (2) Click the **envelope icon** (✉); and (3) **Click Compose New Message**. Or, mail to: HealthSecure HRA, PO Box 4389, Clinton, IA 52733-4389.

Complete this form and send it to the HealthSecure HRA Plan prior to transmitting your initial employer account contribution or to make a change to your current investment allocation. NOTE: The exercise of investment discretion or control could cause employer account funds to be subject to investment limitations, if any, for public funds prescribed by state law.

1. EMPLOYER INFORMATION

Employer Name		Employer ID No.	
Mailing Address		City	State
		Zip	

2. INVESTMENT SELECTION/ALLOCATION CHANGE

Please use whole numbers; no fractions.

<p>Money Market</p> <p>Vanguard Federal Money Market _____ %</p> <p>Bond</p> <p>Columbia US Treasury Index Institutional _____ %</p> <p>Lifestyle</p> <p>Vanguard LifeStrategy Growth Investor _____ %</p> <p>Vanguard LifeStrategy Cons. Growth Investor _____ %</p> <p>International</p> <p>Vanguard Developed Markets Index Admiral _____ %</p> <p>Large Cap</p> <p>Vanguard 500 Index Admiral _____ %</p> <p>Vanguard Windsor Admiral _____ %</p> <p>American Funds Growth R6 _____ %</p>	<p>Mid Cap</p> <p>Vanguard Selected Value _____ %</p> <p>Vanguard Mid-Cap Index Admiral _____ %</p> <p>Vanguard Mid-Cap Growth Investor _____ %</p> <p>Small Cap</p> <p>Vanguard Small-Cap Growth Index Admiral _____ %</p> <p>Vanguard Small-Cap Value Index Admiral _____ %</p> <p style="text-align: right;">Total must equal 100%</p> <p>Rebalance our allocation percentages:</p> <p><input type="checkbox"/> Quarterly <input type="checkbox"/> Annually (end of each calendar quarter/year)</p> <p>Rebalancing is an important feature that will redistribute your entire account balance according to your most recent allocation percentages on file. If selected, this option will continue until revoked online or via written notice to the Plan.</p>
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3. PROJECTED WITHDRAWALS

Please indicate below the approximate amount and frequency of withdrawals (claims) you expect to make from your employer account.

Monthly: We intend to submit an employer account claim of approximately \$ _____ on or around the _____ day of each month to reimburse employer-paid qualified insurance premiums.

Other: We **do not** intend to submit monthly employer account claims, but **do** expect to submit claims as described below. Please provide detail (e.g. approximate amount, frequency, etc.):

None: We have no set strategy at this time. We will notify the Plan when such a strategy is to be implemented.

4. AUTHORIZING SIGNATURE (required)

I hereby authorize the HealthSecure HRA Plan to invest employer account funds as per the fund selection stated above.
Your handwritten signature is required; e-signatures are not acceptable.

X _____ Date _____
Authorized Signature on behalf of Employer

Printed Name

(_____) _____
Area Code and Phone Number

E-mail Address

More Information HealthSecureHRA.com | **Ask Questions** 1-888-364-5027