

HealthSecure HRA®
Authorized Representative Certification

This form may be used when the Authorized Representative is
unable to produce documents identifying a court-ordered estate
representative or a state-approved form of a Small Estate Affidavit.



Mail completed form to: HealthSecure HRA, PO Box 4389, Clinton, IA 52733-4389.

1. DECEASED ACCOUNT HOLDER INFORMATION

Account Number(s)

Social Security Number

Date of Birth (mm/dd/yyyy)

Last Name

First Name

M.I.

2. AUTHORIZED REPRESENTATIVE INFORMATION and REQUIRED SIGNATURE

Last Name

First Name

M.I.

Mailing Address

City

State

ZIP

Area Code and Phone Number

Email Address (use home or personal email address)

Relationship to Deceased Account Holder

By signing below, to the extent permitted by law, this certification is a declaration under penalty of perjury under applicable state and federal law that each of the following is true and correct to the best of your knowledge:

a. I am one of the following:

A surviving adult child of the deceased account holder; or

The sole successor or legal representative of the estate of this account holder and no other person has claimed to be the personal representative of such estate.

b. The deceased account holder listed in Section 1 had no spouse at the time of his or her death or the spouse does not have legal capacity to handle the settlement of this account.

c. No application or petition by another party for the appointment of Personal Representative is pending or has been granted in any jurisdiction.

d. I agree that I will act on my behalf and as an agent and fiduciary on behalf of any other individuals who may have a valid interest in the decedent's account. The Plan may, in its discretion, make final payments in my name or to other individuals as I direct. I understand it is my responsibility to ensure such final payments are administered in accordance with the law and my obligations as agent and fiduciary for the decedent's account.

e. At least 40 days have elapsed since the account holder's date of death.

I indemnify and hold harmless the Plan, Trust and all Trust service providers from any claims or other losses or damages that arise as a result of my knowingly providing false information on this form or for gross negligence or willful misconduct on my part with respect to the handling of the decedent's HRA account as an agent and fiduciary of the decedent's account and estate.

Signature of Authorized Representative

Date (mm/dd/yyyy)