



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

**TIME SENSITIVE:** You must submit this form within 180 days of receipt.

**IMPORTANT! READ THIS FIRST:** References to "original" participant throughout this form mean the deceased participant to whom the original health reimbursement arrangement (HRA) belonged before any transfer. **If you are the surviving spouse of the original participant and do not submit this form within 180 days**, your account will be opened automatically using his or her information and prior elections on file, including investment allocation. **If you are an eligible survivor of the original participant other than his or her spouse and do not submit this form within 180 days**, you will: (a) not become a participant in the HealthSecure HRA plan; and (b) forfeit any portion of the HRA that could have been transferred to you.

We will mail a Welcome Packet to you after your account has been opened. Your Welcome Packet will contain:

- Confirmation of your transferred HRA funds;
- Confirmation of your investment allocation and how to make changes;
- **A Plan Summary/Summary Plan Description**, which you should read carefully; and
- Instructions for online account access and how to file claims.

**This is a two-sided form. Please carefully complete all sections on both sides.**

### Disclaim the HRA

You have the right to disclaim (give up) your share of the original participant's HRA. If you disclaim this benefit, you will forfeit your portion of the HRA to the original participant's employer. Consider this option carefully, and make your choice below.

- I want to keep the HRA. (Skip to Section 1, and fully complete the rest of this form.)
- I want to disclaim (give up) the HRA. (Enter the required information below and sign. You do not need to complete the rest of this form.)

Original Participant Name

Original Participant SSN or Acct No.

Survivor Name

Phone Number

I hereby elect to disclaim my right to any portion of the original participant's HRA account listed above. The HealthSecure HRA plan does not endorse, approve, nor in any manner make a determination regarding whether disclaiming the HRA Participant Account is suitable for any individual.

Signature

Date (mm/dd/yyyy)

### 1. ORIGINAL PARTICIPANT'S INFORMATION

Last Name

First Name

M.I.

Social Security Number or Acct. No.

Date of Birth (mm/dd/yyyy)

### 2. NEW ACCOUNT HOLDER'S INFORMATION

Last Name

First Name

M.I.

Social Security Number

Date of Birth (mm/dd/yyyy)

Male  Female

Mailing Address

City

State

Zip

( )  
Area Code and Phone Number

E-mail Address (Use home or personal email address.)

Certifications, Investment selection and e-services on reverse ►►

More Information [HealthSecureHRA.com](http://HealthSecureHRA.com) | Ask Questions 1-888-364-5027

