HEALTH REIMBURSEMENT ARRANGEMENT
ELECTION FORM

To enroll, complete the following information, sign the form and return it to your Human Resources Representative. PLEASE PRINT OR TYPE

PLAN INFORMATION

GROUP/EMPLOYER NAME: **PLAN YEAR:**

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME ______________________ (LAST FIRST MI) **DATE OF HIRE** ***(Required)*** __________ (MMDDYY) SOCIAL SECURITY NUMBER __________

HOME ADDRESS ______________________ (NUMBER AND STREET, CITY, STATE, ZIP CODE)

DATE OF BIRTH ________ (MMDDYY) E-MAIL ADDRESS __________ PHONE NUMBER __________ GENDER ❑ M ❑ F LOCATION/DEPARTMENT __________

PARTICIPANT'S EFFECTIVE PLAN DATE __________ (Only if different than beginning of Plan Year shown above) DATE OF FIRST PAYROLL DEDUCTION__________ (MMDDYY)

ENROLLMENT INFORMATION

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ❑ SINGLE Amt: $__________ ❑ FAMILY Amt: $__________

❑ I would like to request an additional card for my spouse or tax dependent:

ADDITIONAL CARDHOLDER NAME __________ DATE OF BIRTH __________ SOC. SEC # __________

TERMS AND CONDITIONS

Qualifying Medical Care: I understand that reimbursement will be available only for "qualifying medical care expenses" as listed under Section 213. These expenses must be incurred while I am enrolled in the Plan. I agree to notify the Plan Sponsor or MGIS if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense paid for with the *MGIS Benefits Purchasing* card that is not allowed under Sections 213. I attest that I understand claimed medical expenses can not be reimbursed under the Plan if the expense has been or will be paid in the future by any other plan and **acknowledge that the medical expenses have not been reimbursed or are not reimbursable under any other insurance plan coverage.** I further acknowledge that I am responsible for keeping all receipts verifying all eligible expenses claimed under the Plan and must submit such receipts to MGIS for claims substantiation, upon request.

AUTHORIZATION

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

MGIS (Medical Group Insurance Services) is authorized to use or disclose my protected health information for the purpose of administering my Section 105 account. **I further authorize MGIS (Medical Group Insurance Services) to release my protected health information to my spouse and/or my tax dependent(s). I understand that I may decline disclosure of my protected health information (to my spouse and/or tax dependent(s)) by submitting a written notification to MGIS (Medical Group Insurance Services).** All protected health information pertaining to the reimbursement of a Section 105 claim may be used and disclosed by MGIS (Medical Group Insurance Services).

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to MGIS, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that MGIS (Medical Group Insurance Services) already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage by MGIS (Medical Group Insurance Services) and, by law, MGIS (Medical Group Insurance Services) has a right to contest the coverage. I understand that this authorization expires upon termination of my employer's plan.

❑ I have read the Terms and Conditions of this form and hereby agree to the terms of the disclosure by signing this form.

PARTICIPANT'S SIGNATURE X	**DATE**
HR's SIGNATURE X	**DATE**