PARTICIPATION FORM FOR THE Health Reimbursement Arrangement

Please return this form to your Employer

Employer Name: **Lake Superior School District #381**

Employee Name:

Social Security #: Date of Birth:

Address:

City: State: Zip:

Email: Phone #:

Dependents	
Spouse Name:	
Child Name:	
Child Name:	
Child Name:	

Select which Health Reimbursement Arrangement to be Enrolled

○ **Integrated Health Reimbursement Arrangement**
(Non HSA Participants)

○ **Limited Vision and Dental Health Reimbursement Arrangement**
(HSA Compatible - Reimburses vision and dental expenses only)

○ **Post-Deductible Health Reimbursement Arrangement**
(HSA Compatible – Must meet current IRS minimum deductible annually before plan will reimburse)

Total HRA amount to be contributed per Plan Year: $3000.00 (prorated for mid-year entrants)

HRA funds will be contributed on a monthly basis. One twelfth (1/12th) of the annual amount will be credited at the end of each month. Only current funds balances will be available for reimbursement. Excess claims will be carried over and will be reimbursed when future funds are recorded. The Summary Plan Description (SPD) explains this plan in greater detail.

I hereby certify the above information to be correct and true to the best of my knowledge and that the children or dependent or are legally dependent on me for at least 50% of their support

Employee Signature:	**Date:**