NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS
HEALTH FUND
P.O. BOX 4002, EAU CLAIRE, WI 54702 ~ PHONE: 800-424-3405

Health Reimbursement Account (HRA) Election Form Authorizing Automatic Deduction of Quarterly Premium or Retiree Premium Payments

The North Central States Regional Council of Carpenters Health Fund (the "Plan") offers a Health Reimbursement Account Program that allows you to be reimbursed for Qualifying Medical Expenses that have been submitted to the Plan and Qualifying Premium Expenses, provided you have a sufficient balance in your Health Reimbursement Account (HRA). The Plan document identifies Qualifying Medical Expenses and Qualifying Premium Expenses eligible for HRA reimbursement, *i.e.*, amounts you owe for medical care or premium expenses as defined under section 213(d) of the federal tax code.

If you are an Employee or Retiree and you will not have sufficient Employer contributions in a Contribution Quarter to maintain eligibility during the subsequent Coverage Quarter, you may authorize the Fund Office to automatically deduct the required quarterly payment amount (as applicable) from your HRA to pay for coverage for you and your Dependents. To provide this authorization, please complete this claim form and return it to the address listed at the bottom of this form. The Plan will implement your automatic deduction authorization as soon as administratively feasible after receiving your election.

If you do not want quarterly payment amounts required to maintain coverage under the Plan automatically deducted from your HRA when your Employer contributions are insufficient to maintain coverage under the Plan, do not fill out this form.

Participant Information

_____

Participant's Name - Please Print *ID Number*

_____

Address *City* *State* *Zip Code*

_____ _____

Phone Number *Date of Birth*

Health Reimbursement Account Automatic Deduction

☐ **I WANT** the Fund Office to automatically deduct from my Health Reimbursement Account (HRA) the quarterly payment amount required to maintain eligibility in the Plan (as established from time-to-time by the Trustees) during any Coverage Quarter for which insufficient contributions are received in the preceding Contribution Quarter to maintain coverage under the Plan. I understand that in the event that I do not have sufficient Employer contributions in a Contribution Quarter to maintain Plan eligibility, the Fund Office will automatically deduct the quarterly payment amount required to maintain Plan eligibility from my available HRA balance.

Participant Authorization

By signing below, I authorize the Plan, until otherwise instructed, to deduct from my HRA the amount required in any quarter to maintain coverage under the Plan should contributions received from my Employer during any Contribution Quarter be insufficient to maintain Plan coverage. I certify that I will not seek other reimbursement nor claim a federal tax deduction for the amount(s) deducted from my HRA for my premium payment(s). I also understand that if my HRA balance is reduced to less than the amount required to maintain Plan eligibility for a given Coverage Quarter, I will need to make a monthly or quarterly self-payment (as applicable) by the due date for the payment or my Plan coverage will be discontinued. I understand that the due date will not be extended. Furthermore, I understand that any request to revoke this authorization must be made in writing to the Fund Office at the address provided in this form and that the automatic deduction arrangement will be discontinued as soon as administratively feasible.

_____

Participant's Signature *Date*

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Election Form Submission

Mail completed form to: North Central States Regional Council of
Carpenters Benefit Funds
P.O. Box 4002
Eau Claire, WI 54702