HEALTH REIMBURSEMENT ACCOUNT PLAN
OPT OUT FORM

EMPLOYER: _____

EMPLOYEE NAME: _____ **MEMBER ID:**_____

Participation in the Section 105(h) Health Reimbursement Account Plan (HRA) is automatic for all eligible employees. Under this plan, your employer contributes a certain amount of money on a tax-free basis that you can use for eligible medical expenses.

You will continue to be a plan participant as long as you meet the eligibility requirements unless you opt out of participating in the plan. In order to opt out, this completed and signed form must be returned to your employer.

I understand that by opting out of the plan:

- That I will not be reimbursed for any eligible expenses provided after opting out.
- That I can continue to submit claims for reimbursement of eligible expenses provided prior to the opt out date within the time frame indicated in Section B of my Plan Highlights.

Employee Signature: _____ ***Date:*** _____

Employer Use:

Employer Authorization Signature: _____

Participant's Date of Ineligibility: _____

September 2016

BRi Benefit Resource, Inc.