Opt-out Health Reimbursement Arrangement (HRA)

Spousal Health Plan Attestation Form

Return completed form to:
MidAmerica Administrative & Retirement Solutions
Attn: HRA Admin, P.O. Box 24927 Lakeland, FL, 33802 | claims@MyMidAmerica.com
Fax 863.577.4460 855.329.0095 | www.MyMidAmerica.com

1 YOUR INFORMATION

Please Print.

Employer / Plan Sponsor Name: _____

Employee / Participant Name: _____

Address: _____ City, State, Zip: _____ Last four digits of SSN: ____

Daytime Phone Number: (_____)_____ Date of Birth: _____ Personal Email Address: _____

2 ATTESTATION

I attest that the following regarding enrollment in a spousal health plan:

-I am enrolling as a dependent in my spouse's group health plan for the _____ calendar year.
-My spouse's group health plan is not limited to excepted benefits.
-My spouse's group health plan provides minimum value.

In the event the above item changes, I will immediately notify the Employer/Plan Sponsor listed above.

Participant Signature: _____