MidAmerica
Administrative & Retirement Solutions

Health Reimbursement Arrangement (HRA) Beneficiary Designation Form

Section A: General Information:

Employer (District) Name:			
Employee Name (Last, First, M.I.):		Social Security #:	
Address:			
City:		State:	Zip:
Home Telephone:	Work Telephone:	E-Mail Address:	
Date of Birth:	Date of Hire:		

Section B: Beneficiary Designation

Upon the death of a participant, the participant's surviving spouse and/or dependents are eligible to be reimbursed under this plan for their eligible medical expenses until the vested account balance is exhausted. If a balance remains after the death of the spouse and all dependents, the participant's beneficiaries shall be eligible for medical expense reimbursements permitted under the plan until the account balance is exhausted.

Primary Beneficiary

(If additional space is required, please attach a separate page.)

Name (Last Name, First Name, M.I.)	Social Security Number	Date of Birth (Mo/Day/Yr)	Relationship to Participant	% Share
Address		City	State	Zip Code

Contingent Beneficiary

Name (Last Name, First Name, M.I.)	Social Security Number	Date of Birth (Mo/Day/Yr)	Relationship to Participant	% Share
Address		City	State	Zip Code
Name (Last Name, First Name, M.I.)	Social Security Number	Date of Birth (Mo/Day/Yr)	Relationship to Participant	% Share
Address		City	State	Zip Code

Section C: Internet Access for Plan Participants

MidAmerica Administrative & Retirement Solutions provides Internet access for employee inquiries and questions regarding company retirement plan accounts. Our website address is www.mymidamerica.com. Live operator assistance is available Monday through Thursday from 8:30 a.m. to 8:00 p.m., and Friday 8:30 a.m. to 6:00 p.m., Eastern Time, at our toll-free number (855) 329-0095.

Section D: Participant Certification and Signature

By signing below, I agree that the funds involved and associated financial risks have been described to me such that the allocation selection is based on my best prudent understanding in the interest of my retirement funding goals. I also understand that if I outlive my spouse, dependents and Primary Beneficiary, benefits will forfeit to my employer upon my death unless I designate a Contingent Beneficiary(ies).

Employee Signature _____ **Date** _____

Please return this completed form to:

MidAmerica Administrative & Retirement Solutions
Attn: HRA Department
P.O. Box 149, Lakeland, Florida 33802-0149
Email: Forms@myMidAmerica.com