Limited Scope VEBA HRA Coverage Election Form

E-mail, fax, or mail completed form to the third-party administrator:

MONTANAVEBA
HEALTH REIMBURSEMENT ACCOUNT

Montana VEBA HRA Third-party Administrator (TPA)
Rehn & Associates | PO Box 5433 | Spokane, WA 99205-0433 | Phone **1-800-832-2101** | Fax **(509) 535-7883** | E-mail: **montana@rehnonline.com**

Limited Scope Montana VEBA HRA plan coverage covers only IRS qualified dental, visions, and long term care expenses (subject to IRS limitations). All other expenses incurred while coverage is limited are not eligible.

HSA contribution eligibility: To become eligible to make or receive contributions to a health savings account (HSA), you must first limit your Montana VEBA plan coverage. Keep in mind that limiting your Montana VEBA plan coverage is not the only HSA contribution eligibility requirement. You should check with your HSA provider, but generally, an adult can contribute to an HSA if they (1) have coverage under an HSA-qualified high deductible health plan (HDHP); (2) have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care, or long term care insurance is permitted); (3) are not enrolled in Medicare; and (4) cannot be claimed as a dependent on someone else's tax return.

❶ PARTICIPANT PERSONAL INFORMATION

_____ _____ _____
Last Name First Name Participant Account No. or SSN

_____ (_____) _____
E-mail Address (home or personal recommended) ☐ Check here if new e-mail address Area Code and Phone No.

_____ _____ _____ _____
Mailing Address ☐ Check here if new address City State Zip

❷ LIMITED SCOPE COVERAGE ELECTION

Your limited scope VEBA HRA plan coverage election will remain in force until you make a change. You can make one limited scope coverage election per calendar year. For example, if you turn on limited scope coverage in June, you must wait until the following January to turn off limited scope coverage and change back to full coverage. More than one change during a calendar year may be allowed if you want to change your election shortly after certain life events. For instance, you may be allowed to make a change within 30 days of losing other health coverage or acquiring a spouse or dependent through marriage, birth, or adoption. **All systematic withdrawals from your account (excluding dental and vision premiums) will stop immediately with your limited scope coverage start date.**

You may not enter a period in the past. If you enter a month and year in the past, your election will become effective on the first of the month following Rehn & Associate's receipt of this completed form.

Please check the appropriate box and enter the month and year you want to **START** or **END** limited scope VEBA HRA plan coverage.

☐ **START** limited scope VEBA HRA plan coverage beginning _____ / _____
Month Year

☐ **END** limited scope VEBA HRA plan coverage beginning _____ / _____
Month Year

❸ REQUIRED AUTHORIZING SIGNATURE

By signing below, you hereby elect or revoke limited Scope Montana VEBA HRA plan coverage as described above for you and your eligible spouse and dependent(s), if any. This election or revocation of limited Montana VEBA HRA plan coverage shall be effective from the first day of your selected beginning month/year and shall continue until further notice. Submitting this completed form does not confirm your eligibility to contribute to an HSA. The Montana VEBA HRA plan is not responsible for determining your eligibility to contribute to an HSA or your maximum annual HSA contribution amount.

X_____ _____
Participant Signature Date