Local 434 Health and Welfare Fund
Dollar Bank Election Form
FOR AUTOMATIC REIMBURSEMENT OF MEDICAL EXPENSES

A Dollar Bank has been established for you which allows you to be reimbursed for eligible medical expenses that have been submitted to the group health plan offered under the Local 434 Health and Welfare Fund (the "Plan") provided you have a sufficient balance in your Dollar Bank. The Plan document identifies medical expenses eligible for a Dollar Bank reimbursement, *i.e.*, amounts you owe for medical care as defined under section 213(d) of the federal tax code. You have an option regarding the manner in which your dollars can be reimbursed to you for the out-of-pocket expenses you owe for medical care under the Plan.

If you would like to have your (including your dependents) deductible and coinsurance amounts paid directly and automatically from your individual Dollar Bank, then complete and return this Election Form. This option allows eligible medical expenses that have been submitted to the Plan to also be considered as a claim under the Dollar Bank. After claims are processed by the Plan, your out-of-pocket medical expenses will be reviewed for automatic payment as an eligible medical expense from the Dollar Bank. If you do not elect this automatic option, then you may continue submitting Dollar Bank reimbursement requests on forms available from the Plan Office.

Return the completed Election Form to:

Local 434 Health and Welfare Fund
3001 Metro Drive, Suite 500
Bloomington, MN 55425.

1. Participant Information

Participant Name (First, Middle Initial, Last) ______________________		Social Security Number ______________
Gender ☐ Female ☐ Male	Marital Status ☐ Married ☐ Single	Date of Birth _______ /_____/ _________ Month Day Year
Home Phone Number (________) __________________ Area Code		
Address, City, State, Zip ______________________		

2. Dollar Bank

☐ **I DO** WANT MY DEDUCTIBLE AND COINSURANCE AMOUNTS AND THE DEDUCTIBLE AND COINSURANCE AMOUNTS OF MY DEPENDENTS (IF ANY) PAID AUTOMATICALLY FROM MY DOLLAR BANK ACCOUNT. I UNDERSTAND THAT I WILL ONLY RECEIVE REIMBURSEMENT OF MONEY FROM ASSETS IN EXCESS OF THE COST FOR TWO MONTHS WORTH OF ELIGIBILITY IN MY DOLLAR BANK. CLAIMS INCURRED PRIOR TO THE EFFECTIVE DATE OF THIS ELECTION WILL NOT BE AUTOMATICALLY REIMBURSED BY THE DOLLAR BANK.

(over)

3. Participant Authorization

I understand that by signing below, I am confirming that I want my deductible and coinsurance amounts and the deductible and coinsurance amounts of my dependents (if any) paid automatically from my Dollar Bank account and authorize the Plan to treat my claims submitted to the Plan as if they are made both under the Plan and the Dollar Bank reimbursement program. Further,

I understand that automatic reimbursements under the Dollar Bank will only be made for eligible medical expenses as defined under section 213(d) of the federal tax code and under guidance issued by the Internal Revenue Service for health reimbursement arrangements.

I understand that I cannot submit paper claims for payment of these deductible and coinsurance expenses from the Dollar Bank since the expenses will be automatically paid from my Dollar Bank.

I certify that the claim for a deductible amount or a coinsurance amount was not reimbursed by another health plan and that I will not submit the claim for reimbursement under any other health plan.

I understand that the claim for a deductible or a coinsurance amount that is automatically reimbursed cannot be claimed as a tax deduction for any prior year.

I understand that this election must be revoked if my dependents make or receive contributions to a health savings account.

I understand that this election will remain in force until revoked by me or, if earlier, the date on which I am no longer covered under the Plan.

____________________________________ ____________________________
Participant Signature Date

To revoke an election for automatic reimbursement already in effect, check the box below, complete the Participant Information section and sign above. Your revocation will be put into effect as soon as administratively feasible after it is received by the Plan Office.

☐ I wish to revoke my election for automatic reimbursement.

Please Retain a Copy for Your Records