Heartland Healthcare Fund

PO Box 909500
Kansas City, MO 64190-9500

Wilson-McShane Corporation
Fund Administrators

Telephone: (952) 854-0795
Fax: (816) 756-3659
Toll Free: (800) 535-6373

Health Reimbursement Arrangement Election Form

Your eligibility for the Health Reimbursement Arrangement (HRA) Plan is automatically determined with no enrollment requirement into the Health Reimbursement Arrangement (HRA). However, you have an option regarding the manner in which your HRA dollars can be reimbursed to you.

If you would like to have your (including your dependents) deductible and coinsurance amounts paid directly and automatically from your individual HRA account, then please complete and return this Election Form.

Please note: If you have other additional coverage (for instance, through a spouse), or if you obtain other coverage at any point in the future, you will not be eligible for automatic HRA payments. You will only be eligible to receive reimbursement by submitting claim forms and the appropriate documentation.

Please return this Election Form to: Heartland Healthcare Fund c/o Wilson-McShane Corporation,
PO Box 909500, Kansas City, MO 64190-9500.

1. Participant Information

____ _________________________

Participant Name (First, Middle, Last) Social Security Number

Gender: Marital Status: Date of Birth:

____F _____M _____Married _____Single _______/_______/__________

2. Health Reimbursement Arrangement:

_____ I want to have my deductible and coinsurance amounts paid automatically from my HRA account.

3. Participant Authorization:

____ __________________________

Participant Signature Date

Please retain a copy for your records