The EBC HRA℠

Employee Benefits Corporation

EBC HRA Opt Out Form

Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126** | 608 831 8445
E-mail support: **participantservices@ebcflex.com**

Employee Information

Last 4 Digits of Social Security or Identification Number (Required)

Last Name | Suffix | First Name | MI

Mailing Address | Apt. No. | City | State | Zip Code

Employer Name | Effective Date (mm-dd-yyyy)

Opt Out

☐ Integrated EBC HRA

I elect to "Opt Out" of the EBC HRA integrated with my employer's group health plan. I understand that I will not be able to participate in the EBC HRA until the next plan year regardless of any changes in coverage, family status, eligibility, or any other life event. (If you wish to opt out in future plan years you will need to complete a new EBC HRA Opt Out each year.)

☐ Post-Employment (Spend-Down) EBC HRA

I elect to "Opt Out" and waive access to the account balance that was accumulated in my EBC HRA account due to my termination, retirement or no longer being enrolled on qualifying group health plan coverage. I understand that by opting out of the EBC HRA I will permanently forfeit any balance to my employer.

Opt Out Authorization

I acknowledge and understand my employer has provided me the opportunity to participate in the EBC HRA and/or Post-Employment Benefit EBC HRA. Further, I understand I cannot re-enroll at any time during the plan year for any reason. If I Opt Out of the Post-Employment Benefit, I will not have the ability to re-enroll in the future.

X _____ | Date (mm-dd-yyyy)

Signature

Print Name | Title

