Municipal Employees' Retirement System of Michigan
800.767.MERS (6377)
www.mersofmich.com

Health Care Savings Program Beneficiary Designation Form

Please print clearly • See attached guide for details • Retain a copy for your records

1. Information about you

Last name*	First name*	Social Security Number*	Phone number (with area code)*

Name of employer*	Municipality number (4 digits)*	Plan number (6 digits)*

2. Spouse information

Upon separation of employment, your account becomes available on a tax-free basis for reimbursement of eligible medical expenses incurred by you, your spouse, and legal dependents. Eligible expenses are as defined by the Internal Revenue Code, Section 213. In the event of your death, your spouse and any legal dependents may continue to use the account in this manner. The definition of "legal dependent" is controlled by the Internal Revenue Code 152. See guide for more information. For purposes of reconciling your account, please list your spouse below.

	Name (First, Last)	Date of birth (mm/dd/yyyy)	SSN
Spouse			

3. Beneficiary information

In the event of your death and you have no spouse or legal dependent(s), or in the event of the death of your spouse or legal dependent(s), a named beneficiary may use the account for reimbursement of their medical expenses on a taxable basis.

You may name only one individual as your primary and one as a contingent beneficiary. Do not name your estate or trust, as these entities are not able to use the account for medical expense reimbursement. If you do not designate a beneficiary and are without a spouse and or legal dependent(s), your account balance will revert to your employer's trust in the event of your death.

Primary beneficiary – NOT your spouse, legal dependents, or estate (name only one)

Last name*	First name*	Social Security Number*	Date of birth (mm/dd/yyyy)*	Gender (M/F)*

Mailing address*	City*	State*	Zip*

Phone number (with area code)*	Email address

Contingent beneficiary – NOT your spouse, legal dependents, or estate (name only one)

Last name*	First name*	Social Security Number*	Date of birth (mm/dd/yyyy)*	Gender (M/F)*

Mailing address*	City*	State*	Zip*

Phone number (with area code)*	Email address

4. Required signature

I have completed, understand, and agree to all pages of this *Health Care Savings Program Beneficiary Designation Form* and guide. I hereby revoke all prior beneficiary designations (if any).

Signature of member*	Date (mm/dd/yyyy)*

Data collected on this form will be used by MERS staff for identification and documentation purposes only.

* Required field

Step-by-Step Guide to Completing the Health Care Savings Program Beneficiary Designation Form

This form is available for download at *www.mersofmich.com*, or through your myMERS account.

Please print clearly. Fields with an asterisk (*) are required fields and must be completed to submit the form accurately.

1. Information about you*

If you are completing this form for the first time or have made recent changes to your personal information, please be sure to complete the Personal Information Form (MD-001). You can download the form at *www.mersofmich.com* or call 800.767.6377 to have a form mailed to you.

2. Spouse information

In this section, you'll identify your spouse who, along with any legal dependents at separation from employment, may use the account on a tax-free basis for reimbursement of medical expenses. At the time of reimbursement, you will validate that the claim is for your spouse or a legal dependent.

In the event of death, your spouse and legal dependents continue to use the account on a tax-free basis for reimbursement of medical expenses until the account reaches zero balance.

There are two tests that must be met for a child to be your ***Qualifying Child:***

A. Relationship Test

- Your son, daughter, stepchild, legally adopted child, eligible foster child, or a descendant (for example, your grandchild) of any of the, **OR**
- Your brother, sister, half brother, half sister, stepbrother, stepsister, or a descendant (for example, your niece/nephew) of any of them

B. Age Test – Under age 26

There are three tests that must be met for a person to be your ***Qualifying Relative:***

A. Not a Qualifying Child Test

A child is not your qualifying relative if the child is your qualifying child or the qualifying child of anyone else

B. Member of Your Household or Relationship Test

- Lives with you all year as a member of your household

  OR

- Is related to you in one of these ways:
  - Your child, stepchild, legally adopted child, eligible foster child, or a descendant of any of them (for example, your grandchild)
  - Your son, daughter or stepchild, legally adopted child, eligible foster child, descendant or any of them (for example, your grandchild)
  - Your brother, sister, half brother, half sister, stepbrother, or stepsister.
  - Your father, mother, grandparent, or other direct ancestor, but not foster parent
  - Your stepfather or stepmother
  - A son or daughter of your brother or sister
  - A brother or sister of your father or mother
  - Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law

C. Support Test – They meet the support test if you provide more than half of that person's total support during a calendar year.

3. Beneficiary information

At the time of your death, if you have no spouse or legal dependent(s), or in the event of the death of your spouse or legal dependent(s), a primary and contingent beneficiary can be named. A beneficiary must be an individual and not your estate or trust. You may view your beneficiary information by logging into your myMERS account at *www.mersofmich.com*.

Primary Beneficiary (You may name only one.)
In the event of your death and there is no spouse or legal dependant(s), the primary beneficiary may use the account for taxable medical expense reimbursements.

Contingent Beneficiary (You may name only one.)
In the event of your death and there is no primary beneficiary or after the death of your primary beneficiary, the contingent beneficiary may use the account for taxable medical expense reimbursements.

4. Required signature*

Your signature acknowledges that you have read and agree to the terms of this agreement. Your signature voids all prior designations beneficiaries.

When completed, provide a copy to your employer and mail to MERS' recordkeeper at:

Alerus Retirement Solutions
P.O. Box 64535
St. Paul, MN 55164

You may also upload a copy through your myMERS account under "myProfile"

If you have speech or hearing difficulties and need assistance completing this form, contact the Michigan Relay Center at 800.649.3777. If you have other disabilities, contact MERS at 800.767.MERS (6377) to request special accommodations.