

Chittenden Central Supervisory Union Health Reimbursement Arrangement

Personal Information

WE NEED THE FOLLOWING INFORMATION FOR ALL EMPLOYEES PARTICIPATING IN HEALTH REIMBURSEMENT ARRANGEMENT. DUE TO PRIVACY ISSUES, WE WILL ONLY DISCUSS YOUR ACCOUNT WITH YOU UNLESS YOU HAVE RETURNED THIS COMPLETED FORM.

YOUR NAME:	
MAILING ADDRESS:	
CITY, STATE, ZIP CODE:	PHONE:
E-MAIL :	

MARITAL STATUS: (PLEASE CIRCLE) SINGLE MARRIED CIVIL UNION * SAME-SEX MARRIED* DOMESTIC PARTNER*
<p>* Due to Federal Income Tax Regulations, expenses for Civil Union, Same-Sex Married and Domestic Partners are <u>not</u> eligible for <u>tax-free</u> reimbursements under a Health Reimbursement Arrangement (HRA) unless the partner is considered a dependent and claimed as such on your federal income tax return.</p>

List all eligible dependents, civil union or same-sex married partner or spouse
 (reimbursements for civil union, same-sex married and domestic partners' expenses are considered federal taxable income)

FULL NAME <i>(DO NOT INCLUDE YOURSELF)</i>	Date of Birth	M/F	Relationship To You
JOHN/JANE DOE	00/00/00	M/F	SPOUSE/PARTNER

If the status of your spouse or dependent changes during the plan year as your spouse or dependent, including a new spouse or dependent, you must contact the plan Administrator with these changes immediately.

Those named above, are ____, are not ____ (check one) authorized to discuss the status of my Health Reimbursement Arrangement, including payments of benefits, with Future Planning Associates, Inc.

SIGNATURE:	DATE:
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PLEASE SIGN AND RETURN THIS FORM TO FUTURE PLANNING ASSOCIATES WITH YOUR FIRST CLAIM