

MissionSquare Retirement uses the information on this form to ensure that the assets in the deceased participant's ("decedent") account are allocated in accordance with RHS plan requirements. This form may also be used to notify MissionSquare of the death of the spouse or dependent of the deceased participant.

After completing and signing the form, please submit it to MissionSquare Retirement, P.O. Box 96220, Washington DC, 20090.

Please be sure to keep a copy of all forms and documents you submit for your records.

General Information Regarding Treatment of RHS Account After Death

Participant Survived by Spouse/Dependents: Upon the death of the RHS Plan participant, all claims for decedent's qualified medical expenses should be submitted using the *VantageCare Retirement Health Savings Plan Benefits Reimbursement Request Form*. The surviving spouse and/or surviving dependents[†] are immediately eligible to utilize the funds for reimbursement of qualified medical expenses (as permitted by the plan) on a tax-free basis. An account will be established in the name of the surviving spouse, if any. If there is no spouse, the account will be established in the name of the oldest surviving dependent (or guardian thereof for minor dependents).

†An eligible dependent is (a) the Participant's lawful spouse, (b) the Participant's child under the age of 27, as defined by IRC Section 152(f)(1) and Internal Revenue Service Notice 2010-38, or (c) any other individual who is a person described in IRC Section 152(a), as clarified by Internal Revenue Service Notice 2004-79.

Dependents other than a spouse consist of those who meet the following criteria in the year of the participant's death:

- a. The person is related to the decedent **OR** lived with the decedent for the entire year as a member of the decedent's household, **AND**
- b. The person was a U.S. citizen (or resident of Canada or Mexico) for some part of the calendar year, **AND**
- c. The decedent provided over half of the person's total support for the calendar year.

(See Publication 502, Medical and Dental Expenses, for more information.)

Minor dependents: If no parent resides with the minor, a certified copy of the appointment of guardian by the Court is required before any account transfer can be made. Only one appointment of guardian is required (unless multiple guardians have been assigned for multiple dependents).

Participant Not Survived by Spouse/Dependents: If the participant is not survived by a spouse or any dependents, the remaining account balance will return to the employer's RHS trust.

Death of Survivor: Upon the death of the decedent's surviving spouse and all dependents, remaining RHS assets are returned to the employer's RHS trust. Survivors (spouse and dependents) may not designate a beneficiary under the RHS Plan.

Investment Allocation: The survivor (spouse/dependent as applicable) will be able to reallocate* the funds via Account Access (www.icmarc.org) or an Investor Services Representative after the survivor gains access to the participant's RHS assets.

1. **Participant Information:** Please complete this section carefully. The employer plan number is available from the decedent's employer or MissionSquare. You must attach a certified copy of the death certificate to this form.
2. **Information on the Individual Completing the Form:** This information is required in case we need to contact you further.
3. **Information on Decedent's Spouse:** If the person completing the form is not the spouse, the spousal information section must be completed. If there is no surviving spouse, please check the box marked "No Spouse" and proceed to Section 4.
4. **Dependent Information:** This section provides information on dependents. If you need to designate more than two dependents, please attach a separate sheet of paper. If there are no dependents, please check the box marked "No Dependents" and proceed to Section 6. If there are minor dependents, proceed to Section 5. See the General Information section of these instructions for a definition of "dependent". Changes to dependent information can be made by contacting Meritain Health, Inc. at 888-587-9441.
5. **Guardian Information:** If no parent resides with the minor dependent, attach a certified copy of the Appointment of Guardian to this form. If you need to designate more than two guardians, please attach a separate sheet of paper.
6. **Enclosures:** Please indicate which enclosures you are attaching with this form.
7. **Certification of Individual Completing the Form:** Your signature indicates that you certify the veracity of all information given. After you have completed and signed the form, send it to MissionSquare Retirement, P.O. Box 96220, Washington, DC 20090.

**Before investing, please read the applicable fund disclosure materials carefully for a complete summary of all fees, expenses, investment objectives and strategies, and risks. This information is available when you log in at www.icmarc.org/login, or upon request by calling 800-669-7400.*

- Use this form to notify MissionSquare of:
 - The death of an RHS participant
 - The death of the spouse of a deceased RHS participant
 - The death of a dependent of a deceased RHS participant
- Use blue or black ink. Please keep a copy for your records.

1 PARTICIPANT INFORMATION (NOTE: ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE TO THIS FORM.)

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:	STATE:
NAME OF DECEASED PARTICIPANT: <i>LAST, FIRST, MI</i>		
SOCIAL SECURITY NUMBER:	DATE OF BIRTH: <i>MM/DD/YYYY</i>	DATE OF DEATH: <i>MM/DD/YYYY</i>
MAILING ADDRESS: <i>STREET</i> <i>CITY</i> <i>STATE</i> <i>ZIP</i>		

2 INFORMATION ON INDIVIDUAL COMPLETING THE FORM (NOTE: SEE INSTRUCTIONS ON FIRST PAGE.)

FULL NAME: <i>LAST, FIRST, MI</i>	RELATIONSHIP TO DECEDENT:		
SOCIAL SECURITY NUMBER:	DATE OF BIRTH: <i>MM/DD/YYYY</i>	GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PREFERRED PHONE NUMBER:
MAILING ADDRESS: <i>STREET</i> <i>CITY</i> <i>STATE</i> <i>ZIP</i>			

3 INFORMATION ON DECEDENT'S SPOUSE (NOTE: COMPLETE ONLY IF DIFFERENT FROM SECTION 2.)

NO SPOUSE (PLEASE GO TO SECTION 4) SAME AS SECTION 2 (PLEASE GO TO SECTION 4)

FULL NAME: <i>LAST, FIRST, MI</i>			
SOCIAL SECURITY NUMBER:	DATE OF BIRTH: <i>MM/DD/YYYY</i>	GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PREFERRED PHONE NUMBER:
MAILING ADDRESS: <i>STREET</i> <i>CITY</i> <i>STATE</i> <i>ZIP</i>			

4 DEPENDENT INFORMATION (NOTE: ATTACH A SEPARATE SHEET OF PAPER IF YOU NEED ADDITIONAL SPACE.)

NO DEPENDENTS (PLEASE GO TO SECTION 6)

DEPENDENT A – FULL NAME: <i>LAST, FIRST, MI</i>			RELATIONSHIP TO DECEDENT:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH: <i>MM/DD/YYYY</i>	GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PREFERRED PHONE NUMBER:
MAILING ADDRESS: <i>STREET</i> <i>CITY</i> <i>STATE</i> <i>ZIP</i>			

NO DEPENDENTS (PLEASE GO TO SECTION 6)

DEPENDENT A – FULL NAME: <i>LAST, FIRST, MI</i>			RELATIONSHIP TO DECEDENT:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH: <i>MM/DD/YYYY</i>	GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PREFERRED PHONE NUMBER:
MAILING ADDRESS: <i>STREET</i> <i>CITY</i> <i>STATE</i> <i>ZIP</i>			

5 GUARDIAN INFORMATION (NOTE: ATTACH A CERTIFIED COPY OF THE GUARDIAN APPOINTMENT TO THIS FORM.)

GUARDIAN FOR DEPENDENT A – FULL NAME: <small>LAST, FIRST, MI</small>		
SOCIAL SECURITY NUMBER:	PREFERRED PHONE NUMBER:	
MAILING ADDRESS:		
<small>STREET</small>	<small>CITY</small>	<small>STATE</small> <small>ZIP</small>
GUARDIAN FOR DEPENDENT B (IF DIFFERENT THAN ABOVE) – FULL NAME: <small>LAST, FIRST, MI</small>		
SOCIAL SECURITY NUMBER:	PREFERRED PHONE NUMBER:	
MAILING ADDRESS:		
<small>STREET</small>	<small>CITY</small>	<small>STATE</small> <small>ZIP</small>
<input type="checkbox"/> ADDITIONAL GUARDIANS ON ATTACHED SHEET		

6 ENCLOSURES

I have enclosed the following documents: Participant's Death Certificate (*certified copy*) Appointment of Guardian (*for minor dependents*)

7 CERTIFICATION OF INDIVIDUAL COMPLETING FORM

I certify that the information given on this form is true and complete, and that the spousal, dependent and guardian information provided in Sections 3, 4 and 5 is accurate. By signing this form, I verify that I am the person specified in Section 2, and I realize that the information provided will be used to determine to whom the decedent's account will be transferred.

Signature: _____ Date: MM/DD/YYYY _____