

Health Reimbursement Arrangement (HRA) Participant Enrollment Form



Employer Name _____
Applicant Last Name _____ First Name _____ Middle Initial _____
Social Security Number _____ Date of Birth (mm/dd/yyyy) _____
Address _____ City _____ State _____ Zip _____
Home or Cell Phone _____ Work Phone _____ Email _____

Health Insurance Carrier Information

Insurance Company Name _____
Policy Number _____ Policy Effective Date (mm/dd/yyyy) _____
Coverage Tier: Self Only Self & Spouse Self & Children Family
Premium Amount \$ _____ Monthly Quarterly Semi-Annually Annually

Medicare Secondary Payor (MSP) Reporting Information

Are you a Medicare beneficiary: Yes No If Yes, provide Medicare HICN here: _____

**** IMPORTANT: If your spouse or any of your dependents are covered by the health insurance plan listed above, please complete the form on the reverse side for each person besides yourself who is covered by the plan.**

Payment Information

Reimbursement will be made via Electronic Funds Transfer (Direct Deposit) into your checking or savings account. Please provide bank account information below -OR- attach a voided check.

Routing Transit Number

(All nine boxes must be filled)

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Account Number

(Include hyphens, but not spaces and special symbols)

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I hereby certify information provided herein to be correct and true and choose to participate.

Signature _____ Date (mm/dd/yyyy) _____

Medicare Secondary Payor (MSP) Reporting Information (continued from reverse)

continued from page 1

**** IMPORTANT: If your spouse or any of your dependents are covered by the health insurance plan listed on the reverse side please complete the form below for each person (besides yourself) who is covered by the plan.**

Dependent #1

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

Dependent #2

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

Dependent #3

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

Dependent #4

Name _____ Gender Male Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? Yes No

If Yes, provide his/her Medicare HICN here _____

If you have more than four dependents covered by this health insurance plan, please provide the above information about each person on a separate sheet of paper and attach to this form.