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HRA ENROLLMENT FORM

For internal use only

Form with fields for EMPLOYER, NAME, MAILING ADDRESS, CITY, ST, ZIP, SSN, Birth Date, Effective Date, and gender/marital status options.

I understand that the above named employer will provide the following benefits within the parameters of the health reimbursement arrangement plan document and summary plan description.

HEALTH REIMBURSEMENT ACCOUNT section with fields for HRA AMOUNT, ANNUAL AMOUNT ELECTED, PAY PERIODS, and a note for mid-year changes.

CERTIFICATION (Please read before signing). I certify that these are my proposed benefits and that:

- 1. The dependents for whom I will be claiming medical expenses either reside with me in a parent-child relationship or are legally dependent on me for support.
2. Reimbursement account claims must be accompanied by documentation that deductible minimums have been met.
3. I understand that coverage applies only to expenses incurred during participation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Company Authorization: \_\_\_\_\_ Date: \_\_\_\_\_