ALLEGIANCE
FLEX ADVANTAGE™

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HRA ENROLLMENT FORM
(Including Dependents)

For internal use only

EMPLOYER:	PLAN YEAR ____/____/____ to ____/____/____ ☐ NEW ELECTION ☐ RE-ENROLLMENT ☐ CHANGE
NAME:	SSN
MAILING ADDRESS:	Birth Date____/____/____ ☐-Male ☐-Female
CITY: ST: ZIP:	Effective Date: ____/____/____ (for mid-year adds/changes only) ☐-Married ☐-Single

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

HRA AMOUNT: $_____ per: ☐W ☐BW ☐SM ☐M ☐YEAR (please check one)

ANNUAL AMOUNT ELECTED: $_____ (election X number of pay periods)

PAY PERIODS: "W"=WEEKLY(52); "BW"=BI-WEEKLY(26); "SM"=SEMI-MONTHLY(24); "M"=MONTHLY(12)

****IF THIS ELECTION IS A MID-YEAR CHANGE PLEASE STATE THE REASON FOR THE CHANGE BELOW:**

DEPENDENTS (Use additional paper if necessary)

	FIRST	*M.I.*	*LAST*	SOCIAL SECURITY NUMBER (required by law if over 1 year of age)	BIRTH DATE	SEX M or F
LEGAL SPOUSE						
List Child						
List Child						
List Child						
List Child						

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: _____