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 ______________________

HRA Benefit Name ______________________ **HRA Effective Date** (mm/dd/yyyy) ______________________

Coverage Tier: ❑ Self Only ❑ Self & Spouse ❑ Self & Children ❑ Family

Medicare Secondary Payor (MSP) Reporting Information

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

Payment Information

Reimbursement will be made via the mySourceCard® or by Electronic Funds Transfer (Direct Deposit) into your checking or savings account. For direct deposit, please provide bank account information below -OR- attach a voided check.

❑ I choose the mySourceCard® for my payment method.

I understand that the mySourceCard® is restricted to certain merchant categories and is not accepted at all Mastercard® acceptance locations. I understand that I may not obtain a cash advance with the mySourceCard® at any merchant, bank or ATM. I understand that the Summit Card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the mySourceCard® is issued pursuant to Employer Plans and I use the Card for an expense that is not a Qualified Expense I am indebted to my Employer and must repay the full amount of the non-qualified expense. I agree to save all invoices and receipts related to any expenses paid with the mySourceCard®; upon request I must submit these documents for review by Beneliance. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and I will be required to remit payment to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.

❑ I choose Direct Deposit for my payment method.

Routing Transit Number
(All nine boxes must be filled)

Account Number
(Include hyphens, but not spaces and special symbols)

Signature ______________________________ **Date** (mm/dd/yyyy) ______________

please proceed to page 2

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 HRA 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.

Beneliance
PO Box 55068 | Little Rock, AR 72215 | Toll-Free 877-685-0655 | Toll-Free Fax: 855-445-1696
operations@beneliance.com | beneliance.com

© 2024 BENELIANCE