

# Health Reimbursement Arrangement (HRA) Participant Enrollment Form



Employer Name \_\_\_\_\_  
(Please Print)

Applicant Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yyyy

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ E mail Address \_\_\_\_\_

## Health Insurance Carrier Information

Insurance Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Policy Effective Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

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

I choose the debit card for my payment method.

I understand that the debit card 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 debit card at any merchant, bank or ATM. I understand that the debit card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the debit card 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 debit card; upon request I must submit these documents for review by my benefits administrator. 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.

Additional Card Request, Name: \_\_\_\_\_

Additional Card Request, Name: \_\_\_\_\_

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

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

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

**\*\* 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.**