## Premium Reimbursement Arrangement (PRA) Participant Enrollment Form



Applicant Last Name		First Name _			Middle Initi	
		Date of Birth (mm/dd/yyyy)				
Address		City		State	Zip	
Home or Cell Phone	Work Phone		Email			
Health Insurance Carrier Info	ormation					
nsurance Company Name						
olicy Number		Policy Effective Date (mm/dd/yyyy)				
Coverage Tier: 🗅 Self Only 🗀 S	Self & Spouse 🔲 Self &	Children 🖵 Fam	ily			
remium Amount \$		🗖 Month	ıly 🗖 Quarterl	y 🖵 Semi-Anı	nually 🗖 Annı	
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 $\textbf{Date} \; (\mathsf{mm}/\mathsf{dd}/\mathsf{yyyy}) \, \_$ 

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

\*\* IMPORTANT: <u>If your spouse or any of your dependents</u> are covered by the health insurance plan listed on the reverse side please complete the form below for <u>each person</u> (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	N 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	N 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	N 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	N 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.

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