Premium Reimbursement Arrangement (PRA) Participant Enrollment Form

beneliance

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 _____

Health Insurance Carrier Information

Insurance Company Name _____

Policy Number _____ Policy Effective Date (mm/dd/yyyy) _____

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

Premium Amount $ _____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Reimbursement Acknowledgement

❑ I certify that I will share my claims information with Beneliance for the purpose of processing HRA claims. I understand and accept that I will have to manually submit my Explanation of Benefits (EOBs) to Beneliance for HRA reimbursement should a residual benefit be available after my premiums are reimbursed.

Are you a Medicare beneficiary: ☐ Yes ☐ No Provide Medicare HICN here: _____

Medicare Secondary Payor (MSP) Reporting Information

** **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

Reimbursement will be made via Electronic Funds Transfer (Direct Deposit) into your checking or savings account.
Please provide bank account information below -OR- attach a voided check.

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

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

continued from page 1

** **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 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 | Toll-free: 877-685-0655 | Fax: 501-553-9097 | PO Box 55068, Little Rock, AR 72215
benefits@beneliance.com | beneliance.com