Premium Reimbursement Arrangement (PRA) Participant Enrollment Form

%benelíance

Employer Name					
Applicant Last Name Social Security Number					
Home or Cell Phone	Work Phone	Email			
Health Insurance Carrier Inform	ation				
Insurance Company Name					
Policy Number	Policy Effective Date (mm/dd/yyyy)				
Coverage Tier: 🗅 Self Only 🛛 🗅 Self	& Spouse 🛛 🖬 Self & C	Children 🛛 🗅 Fo	amily		
Premium Amount \$		🛛 Mo	nthly 🛛 Quarterly	🗅 Semi-Anr	nually 🗅 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: ______

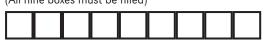
Medicare Secondary Payor (MSP) Reporting Information

** 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)



** 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 Gender 🖵 Male 🖵 Female Name Social Security Number ______ Date of Birth ______ Relationship to You Is this person a Medicare beneficiary? If Yes, provide his/her Medicare HICN here _____ Dependent #2 Gender 🗖 Male 🗖 Female Name _____ Social Security Number Date of Birth Relationship to You _____ 🗆 Yes 🛛 No Is this person a Medicare beneficiary? If Yes, provide his/her Medicare HICN here _____ Dependent #3 Gender 🗅 Male 🗅 Female Name _ Social Security Number Date of Birth Relationship to You Is this person a Medicare beneficiary? If Yes, provide his/her Medicare HICN here **Dependent** #4 _____ Gender 🗅 Male 🗅 Female Name ____ Social Security Number ______ Date of Birth ______ Relationship to You _____ Yes I No Is this person a Medicare beneficiary? 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