HRA Enrollment Form

Employer:

Participant Effective Date:

Employee Information

Last Name* First Name* SSN*

Date of Birth* Email Address* Phone Number

Address* Apt Number

City State Zip

Dependent Information

Dependent Name	Relationship	Date of Birth	SSN
	[ ] Spouse [ ] Child		
	[ ] Spouse [ ] Child		
	[ ] Spouse [ ] Child		

HRA Plan

Please select your coverage option (*your coverage tier must match your Health Plan*):	
[ ]	Employee Only Coverage
[ ]	Employee plus dependents
[ ]	Waive Coverage

I UNDERSTAND THAT:

(1) This is an HRA account provided to me by my Employer to help with medical expenses. I agree to use the debit card solely for the purchase of eligible expenses. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account.
(2) Reimbursed expenses cannot be claimed on my income tax return.
(3) I cannot change or revoke this agreement at any time during the plan year unless I have a qualifying event as defined by the Plan and the Internal Revenue Code.
(4) All funds must be claimed according the terms of the Plan and within specified timeframes. All unused funds will be forfeited at the end of the Plan Year and at termination of employment.
(5) This agreement is subject to the terms of the Company's HRA Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement to such plan(s). By signing this form, I agree to the terms and procedures of the Plan (Please see your SPD for full details).

I wish to participate in the Plan and have indicated my election above. I understand and will abide by the terms of this agreement.

EMPLOYEE SIGNATURE DATE