



# ELECTION FORM FOR THE HEALTH REIMBURSEMENT ARRANGEMENT (COMPREHENSIVE PLAN)

PLEASE COMPLETE ALL FIELDS ON THE FORM AND PRINT CLEARLY AND LEGIBLY

Employer \_\_\_\_\_ Employee Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

## HRA COMPREHENSIVE BENEFIT PLAN COVERAGE ELECTIONS

Single -HRA Benefit Amount \_\_\_\_\_ \*\*Employee+Child(ren) - HRA Benefit Amount \_\_\_\_\_  
 \*\*Employee+Spouse-HRA Benefit Amount \_\_\_\_\_ \*\*FAMILY\*\* HRA Benefit Amount \_\_\_\_\_

**\*\* COVERED MEMBERS. ALL INFORMATION BELOW IS REQUIRED FOR HRA ENROLLMENT. \*\***

1. Covered Dependent (or Spouse) Full Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Medicare HICN # (if applicable) \_\_\_\_\_  
 Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation to Employee \_\_\_\_\_

Does this dependent have End Stage Renal Disease? \_\_\_\_\_

2. Covered Dependent Full Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Medicare HICN # (if applicable) \_\_\_\_\_  
 Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation to Employee \_\_\_\_\_

Does this dependent have End Stage Renal Disease? \_\_\_\_\_

3. Covered Dependent Full Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Medicare HICN # (if applicable) \_\_\_\_\_  
 Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation to Employee \_\_\_\_\_

Does this dependent have End Stage Renal Disease? \_\_\_\_\_

*Use a separate sheet if additional dependents are to be covered.*

## HRA WAIVER/DECLINING COVERAGE

\_\_\_\_\_ (PLEASE INITIAL)

*I have declined the option to enroll in my employer-sponsored insurance benefit for this plan year and understand that I will not be eligible to participate or be reimbursed monies for medical expenses from the HRA.*

The HRA will reimburse up to the specified amount detailed in the my employer's Summary Plan Description and based upon my employer's plan design. I understand that the monies reimbursed under the HRA are provided by my employer for the purpose of medical expenses and that the benefit is free from federal, state and FICA taxation change. My employer and I agree the benefit election set forth above is accurate and that qualified medical expenses eligible as outlined in the Health Reimbursement Arrangement plan design will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each Plan Year; I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I acknowledge that I have received, read and understand the Summary Plan Description. I have also read and understand the Important Information provided with enrollment materials. Certain eligible HRA Comp Plans are designed with the ability to add an HRA Debit Card to the Plan. If applicable, it is imperative you read all details provided with issued card to satisfy IRS requirement for transaction verification.

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

**MUST BE COMPLETED BY EMPLOYER**

Effective Date of HRA Participation (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_ and end \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dept. \_\_\_\_\_ First payroll start date \_\_\_\_/\_\_\_\_/\_\_\_\_ Pay Cycle \_\_\_\_\_