Health Reimbursement Arrangement (HRA) Plan
HRA Enrollment Form

Company Name: ____

Employee Name: ____

Address: ____

Phone:______________________________**Email Address:** ______________________________

Date of Birth: ____

Social Security Number:__________-_______-__________**Participant ID:** ___________________

Effective Date: ____

_____Yes, I want to enroll in the HRA.

The IRS regulation states four conditions: 1) Any expenses you incur must be within the plan year. 2) Any expenses you incur must not be covered by any other source such as insurance. 3) You must provide proper documentation in order to receive payment. 4) You may elect to suspend your HRA Account for any future Plan Year by submitting a Suspension Election Form. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

_______________________________ _______________________________

Participant's Signature Date

_____No, I do not want to enroll in the HRA.

If a change of status occurs, I may have the right to enroll in the plan at that time if my employer's plan allows.

_______________________________ _______________________________

Participant's Signature Date

For Administrator's Use Only:

Received this Form on_________________________, 20____.

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