Health Reimbursement Arrangement (HRA)
Enrollment Form

Participant Information			
Employer Name (Do not abbreviate)			
Last Name	First Name	Initial	Social Security Number
Street Mailing Address			Mobile Number
City, State, Zip Code			Date of Birth
Email Address			Hire Date

Spouse and Dependent Information	Date of Birth	Social Security Number
Spouse Name:		
Dependent Name:		
Dependent Name:		
Dependent Name:		
Dependent Name:		

Employee Signature _____ **Date** _____

Employer Authorization	
Benefit Effective Date:	HRA Contribution Amount:
Benefit/HRA Plan Name	
Employer Representative: _____ Date: _____	