HRA
ENROLLMENT FORM

(Please Print ALL information)

Company Name: _____

Social Security Number:_____/_____/_____ Date of Birth: _____

First Name:_____ M.I.:_____ Last: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone Number:_____ E-Mail Address: _____

I certify the information on this form is accurate, complete and true. I also certify that I will claim reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that the expense(s) has not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these or any other expenses reimbursed through this plan, as an income tax deduction/credit. I understand that I can be reimbursed only for qualified expenses incurred during the plan year.

Employee Signature _____Date_____

FOR EMPLOYER USE ONLY:

Eligibility Date: _____

Dependent Information:

Name: _____ Social Security #:_____ Date of Birth: _____

Name: _____ Social Security #:_____ Date of Birth: _____

Name: _____ Social Security #:_____ Date of Birth: _____

Name: _____ Social Security #:_____ Date of Birth: _____

Name: _____ Social Security #:_____ Date of Birth: _____

Name: _____ Social Security #:_____ Date of Birth: _____

Notes:

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_____

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