



First Benefit Administrators

# HRA ENROLLMENT FORM

Please PRINT Clearly

|                       |  |   |   |       |
|-----------------------|--|---|---|-------|
| EMPLOYER              | DEPT/LOCATION  | SOCIAL SECURITY NUMBER  | <input type="checkbox"/> 12 MONTH PLAN YEAR<br><input type="checkbox"/> Short Plan Year |       |
| EMPLOYEE'S FIRST NAME |  | MIDDLE NAME   | LAST NAME   |       |
| ADDRESS               |  | CITY  | STATE   | ZIP   |
| EMPLOYEE BIRTH DATE   | SEX  | <input type="checkbox"/> Single<br><input type="checkbox"/> Limited Family<br><input type="checkbox"/> Family | SPOUSE' NAME  | PHONE |
| DAYTIME PHONE NUMBER  | <i>(Employer Complete)</i> Employee Effective Date For Plan<br>_____<br>MONTH/DAY/YEAR |   |   |       |

HEALTH REIMBURSEMENT ACCOUNT TOTAL \$ \_\_\_\_\_

\_\_\_\_\_ 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 incurred must not be covered by any other sources such as Insurance.
- 3) You must provide proper documentation in order to receive payment.
- 4) You cannot change or revoke your election during the plan year unless there is a specific change of status and your employer allows such changes.

\_\_\_\_\_ 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.

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

Mail Completed Forms to: **FIRST BENEFIT ADMINISTRATORS, INC**  
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