

Health Reimbursement Arrangement

Enrollment Form

Please complete this form in its entirety if you desire to participate in the Health Reimbursement Arrangement sponsored by your employer. Once you have completed this form, please return it either in person to your human resources representative. All information you provide will remain confidential.

Personal Information (Please Print):

Employer Name: _____

- Options: [] Employee Only Coverage \$ _____
[] Employee & Spouse Coverage \$ _____
[] Employee & Children Coverage \$ _____
[] Family Coverage \$ _____

Employee Name: _____
Street Address 1: _____
Street Address 2: _____
City, State, Zip: _____

SS #: _____

E-Mail Address: _____

Phone #: _____

Dependents:

Table with 5 columns: Name, Relationship, SS, DOB, Disabled. Includes four rows of blank lines for data entry.

- Preferred Reimbursement: [] Check.
[] Direct Deposit (attach Direct Deposit Authorization)

Authorization:

I hereby certify that the above information is true to the best of my knowledge and belief and that those individuals listed above are my tax dependents.

Date: _____

Employee Signature

Accepted and agreed to:

Date: _____

By: _____

Title: _____