

HEALTHY DOLLARS

HRA BENEFIT ENROLLMENT

Company Name: _____

Employee: _____ SS#: _____ Date of Birth: _____

Date of Hire: _____ Effective Date: _____

Address: _____

Street

City

State

Zip

Email Address: _____

Medicare Beneficiary No Yes, If Yes, Medicare ID: _____

Dependent Info – Please list all eligible dependents & spouse.

Name: (Last, First MI)	Date of Birth	Social Security Number	Medicare ID

I hereby elect to participate in my employers HRA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at anytime throughout the plan year. I also agree that if I cannot produce a copy of the requested receipt the transaction will be deemed ineligible and I will have to refund the plan for the total expenses.

Signature of Employee: _____	Date: _____
------------------------------	-------------

****Waiver of Participation*****

I have been given the opportunity to enroll in the **Health Reimbursement Plan**, but I DO NOT WISH to participate.

Signature of Employee: _____	Date: _____
------------------------------	-------------