

HEALTHY DOLLARS

HRA, FSA & DCA BENEFIT ENROLLMENT

Company Name: _____

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

Date of Hire: _____ Effective Date: _____

Address: _____

Email Address: _____

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

Dependent Info – Please list all eligible dependents & spouse. Please check with plans your dependents are on.

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

	Annual Election	Deduction Per Pay Period	Number of Pay Periods
Health Reimbursement Account		N/A	N/A
Flexible Spending Account (\$2500 Limit)			
Dependent Care Account (\$5000 Limit)			

I hereby elect to participate in my company's HRA, FSA, and/or DCA 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: _____
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****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: _____
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