

HRA ENROLLMENT FORM

Please print clearly

EMPLOYER:		DIVISION:				
SSN:		<input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> CHANGE* EFFECTIVE DATE (mm/dd/yy):				
NAME:		BIRTH DATE (mm/dd/yyyy):				
MAILING ADDRESS:			PHONE:		<input type="checkbox"/> Married <input type="checkbox"/> M <input type="checkbox"/> Single <input type="checkbox"/> F	
CITY:		STATE:	ZIP:	EMAIL:		
I understand that the above named employer will provide the following benefits within the parameters of the health reimbursement arrangement plan document and summary plan description.						
HEALTH REIMBURSEMENT ACCOUNT						
HRA AMOUNT: \$ _____ per: <input type="checkbox"/> W <input type="checkbox"/> BW <input type="checkbox"/> SM <input type="checkbox"/> M YEAR (please check one)						
ANNUAL AMOUNT ELECTED: \$ _____						
♦ PAY PERIODS - 52 = WEEKLY 26 = BI-WEEKLY (every 2 weeks) 24 = SEMI-MONTHLY 12 = MONTHLY						
DEPENDENTS (Use additional paper, if necessary)						
	FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER (required by law if over age 1)	BIRTH DATE	SEX M or F
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CERTIFICATION <i>I certify that these are my benefit elections and that:</i> 1. I understand that coverage applies only to expenses incurred during my period of active participation in the HRA. 2. My HRA election is for expenses for myself, my spouse, and my qualified dependents. 3. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense. Both an employee signature and company authorization are required for enrollment to be completed. Signed: _____ Date: _____ Company Authorization: _____ Date: _____ *If this is an election change, please indicate the qualifying event: _____ HR initials _____						

For Allegiance use only

2024

Group Number: _____ Date Completed: _____ Entered By (initials): _____