ELECTION FORM FOR THE HEALTH REIMBURSEMENT ARRANGEMENT
(BRIDGE PLAN)

Employer _______________________________________ Employee Name ___________________________________

Social Security # _________________________________ Date of Birth ___________________________________

Mailing Address _______________________________________City ____________________State_________Zip_________

Home Phone (_____) _______________________________ E-mail **(recommended)** ______________________________

HRA BENEFIT PLAN COVERAGE ELECTION

Single	**HRA Benefit Amount__________________**
Employee + Spouse **	**HRA Benefit Amount__________________**
Employee + Child(ren) **	**HRA Benefit Amount__________________**
FAMILY**	**HRA Benefit Amount__________________**

** COVERED MEMBERS. ALL INFORMATION BELOW IS REQUIRED FOR HRA ENROLLMENT. **

1. Covered Dependent (or Spouse) Full Name____

Social Security Number____________________________ Medicare HICN # (if applicable)__________________

Gender____________________________ Date of Birth___________________ Relation to Employee__________________

Does this dependent have End Stage Renal Disease?____________

2. Covered Dependent Full Name____

Social Security Number____________________________ Medicare HICN # (if applicable)__________________

Gender____________________________ Date of Birth___________________ Relation to Employee__________________

Does this dependent have End Stage Renal Disease?____________

3. Covered Dependent Full Name____

Social Security Number____________________________ Medicare HICN # (if applicable)__________________

Gender____________________________ Date of Birth___________________ Relation to Employee__________________

Does this dependent have End Stage Renal Disease?____________

Use a separate sheet if additional dependents are to be covered.

On the appropriate benefit enrollment form, I have enrolled in a qualified employer-sponsored insurance benefit(s) (i. e. health, dental, vision or other qualified insurance, etc.) I understand that by participating in my employer-sponosored health plan that I am considered an eligible participant in the Health Reimbursement Arrangement (HRA). The HRA will reimburse up to the specified amount detailed in the my employer's Summary Plan Description and based upon my employer's plan design. I understand that the monies reimbursed under the HRA are provided by my employer for the purpose of medical expenses and that the benefit is free from federal, state and FICA taxation change.

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HRA WAIVER/DECLINING COVERAGE

__________ (PLEASE INITIAL)

I have declined the option to enroll in my employer-sponsored insurance benefit for this plan year and understand that I will not be eligible to participate or be reimbursed monies for medical expenses from the HRA.

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My employer and I agree the benefit election set forth above is accurate and that qualified medical expenses eligible as outlined in the Health Reimbursement Arrangement plan design will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each Plan Year; I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I acknowledge that I have received, read and understand the Summary Plan Description. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: ____**Date**______________________________

TO BE COMPLETED BY EMPLOYER

Plan year start (mm/dd/yy) _____/______/_____ and end _____/_____/_____

Dept. ________________________________ First payroll start date _____/____/_____ Pay Cycle ___________________

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