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ELECTION FORM FOR THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA BRIDGE PLAN)

PLEASE COMPLETE ALL FIELDS ON THE FORM AND PRINT CLEARLY AND LEGIBLY

Employer _____ Employee Name _____
 Social Security # _____ Date of Birth _____
 Mailing Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ E-mail _____

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-sponsored 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. Certain eligible HRA Bridge Plans are designed with the ability to add an HRA Debit Card to the Plan. If applicable, it is imperative you read all details provided with issued card to satisfy IRS requirement for transaction verification.

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.

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 _____

MUST BE COMPLETED BY EMPLOYER

Effective Date of HRA Participation (mm/dd/yy) ____/____/____ and end ____/____/____
Dept. _____ First payroll start date ____/____/____ Pay Cycle _____

10/2018 version