



Name of Company
Health Reimbursement Arrangement (HRA) Enrollment Form
For the Plan Year Plan year--from --to
Payroll Effective: _____
Enrollment Form Turn In Date: Form turn in date
Order mySourceCard: Yes No

Employee Name (Last, First, MI) *Please Print* _____ Phone Number _____
 Employee Street Address _____ City _____ State _____ Zip Code _____
 Date of Birth _____ Social Security Number _____
 E-mail address (Required for the debit card) _____ Mother's Maiden Name (Security Purposes Only) _____
 Print Name as it will appear on 1st Card (21 characters max) _____ Print Name as it will appear on 2nd Card (Optional) (21 characters max) _____

Health Reimbursement Account Allocation: HRA Amount (If applicable): \$ _____

Health Plan Status: (Circle One): Single Employee/Spouse Parent/Child Family

Are you currently or have you ever been enrolled in Medicare? Yes No (Circle One)
 If yes, you must provide your Medicare Claim Number (HICN) _____

Spouse Name: _____ Soc. Sec. #: _____ Date of Birth: _____
 Address (If different than employee's): _____

Is your spouse currently or has he/she ever been enrolled in Medicare? Yes No (Circle One)
 If yes, you must provide your Medicare Claim Number (HICN) _____

Dependents:

Names	Date of Birth	Soc. Sec. #s	Address (If different from employee's)

(List any others with above information on the back of this form)

Are any of your dependents currently or have they ever been enrolled in Medicare? Yes No (Circle One)
 If yes, please list names of dependents below. *(Use back of form for more space)*

If yes, you must provide your Medicare Claim Number (HICN) _____

I understand that: The plan administrator may reduce or cancel my Health Reimbursement Plan or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code or for any other reason within its discretion if such modification is legally allowable.

**Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires Pacific Benefits iFlex to report certain HRA Enrollment data to the Centers for Medicare & Medicaid Services.*

Please return this signed agreement to your Benefits/Human Resource administrator.

Employee Signature _____ Date _____