

**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**

\_\_\_\_\_  
 Employee Name (Last, First, MI) *Please Print* Phone Number \_\_\_\_\_

\_\_\_\_\_  
 Employee Street Address City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
 Date of Birth Social Security Number \_\_\_\_\_

\_\_\_\_\_  
 Email Address \_\_\_\_\_

**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 \_\_\_\_\_