ENROLLMENT/CHANGE FORM
HEALTH REIMBURSEMENT ACCOUNTS
(PLEASE PRINT CLEARLY)

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

EMPLOYER:

A. EMPLOYEE INFORMATION

Member ID: SSN: Medicare Health Claim Number (HICN): *(if applicable)*

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time ☐ Retired

Email Address: _____
(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

Please check all that apply:
- ☐ End Stage Renal Disease (ESRD)
- ☐ Disabled
- ☐ Current Medicare Beneficiary
- ☐ *Covered by a group health insurance plan *(if required by your plan)*

The purpose of this agreement is to authorize the employer to provide the employee with selected benefits. This agreement is designed to conform with Section 105(h) of the Internal Revenue Code.

B. DEPENDENT INFORMATION ☐ ***Check here if you do not have any eligible dependents. Proceed to Section C.***

☐ Add ☐ Remove
Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____
Last Name: _____ First Name: _____ (MI): ____
Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____
Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:
- ☐ End Stage Renal Disease (ESRD)
- ☐ Disabled
- ☐ Current Medicare Beneficiary
- ☐ *Covered by a group health insurance plan *(if required by your plan)*

☐ Add ☐ Remove
Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____
Last Name: _____ First Name: _____ (MI): ____
Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____
Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:
- ☐ End Stage Renal Disease (ESRD)
- ☐ Disabled
- ☐ Current Medicare Beneficiary
- ☐ *Covered by a group health insurance plan *(if required by your plan)*

☐ Add ☐ Remove
Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____
Last Name: _____ First Name: _____ (MI): ____
Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____
Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:
- ☐ End Stage Renal Disease (ESRD)
- ☐ Disabled
- ☐ Current Medicare Beneficiary
- ☐ *Covered by a group health insurance plan *(if required by your plan)*

(Over Please)

****Effective for plan years that begin on or after January 1, 2017, reimbursement of expenses from your HRA can only be for you, your spouse and/or your eligible dependents who are covered under a group health insurance plan as outlined in your Plan Highlights.***