Interactive Medical Systems

HRA Enrollment Form

EMPLOYEE PROFILE

Employee Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

City: _____ Department: _____

State: _____ Effective Date: _____

Zip: _____ E-mail Address: _____

ELECTION

☐ Yes , I want to enroll in the HRA ☐ No , I do not want to enroll in the HRA

The IRS Regulations stipulate the following conditions:

- Any expenses incurred must be within the Plan Year.
- Any expenses incurred must not be covered by any other source, such as other insurance coverage.
- Proper documentation must be provided in order to receive reimbursement.
- You cannot change or revoke your HRA election during the Plan Year unless there is a specific change is status and your Employer allows such changes.
- Are you Medicare Eligible Yes____No_____ If yes, please be advised it is your responsibility to notify Medicare that you are participating in an HRA. **Medicare may deny your medical claims until your HRA funds are exhausted.**

TYPE OF COVERAGE

Type of coverage: Single ☐ Family ☐

If Family is elected above, please complete the following:

DEPENDENT NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
Spouse:			
Child:			
Child:			
Child:			
Child:			

AUTHORIZATION

Is any enrolled member suffering from End Stage Renal failure? ☐ Yes ☐ No

If yes, provide name of member: _____

By my signature below, I certify that this information is correct, complete and meets all requirements.

Employee Signature _____ Date _____

Company Name _____ Group Number _____