ENROLLMENT/CHANGE FORM
HEALTH REIMBURSEMENT ACCOUNTS

(PLEASE PRINT CLEARLY)

Benefit Resource, Inc.
plans that perform

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

Please check all that apply:

☐ End Stage Renal Disease (ESRD)

☐ Disabled

☐ Current Medicare Beneficiary

Email Address: ____

(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding 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

☐ 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

☐ 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

(Over Please)

☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____ Please check all that apply:

Last Name: _____ First Name: _____ (MI): ____ ☐ End Stage Renal Disease (ESRD)

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____ ☐ Disabled

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____ ☐ Current Medicare Beneficiary

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☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____ Please check all that apply:

Last Name: _____ First Name: _____ (MI): ____ ☐ End Stage Renal Disease (ESRD)

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____ ☐ Disabled

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____ ☐ Current Medicare Beneficiary

C. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that if I or my spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Health Reimbursement Account (HRA).

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law. I verify that the information detailed above is true and accurate. I understand that certain information being requested is necessary to comply with the mandatory Section 111 reporting and will be sent to The Centers for Medicare & Medicaid Services (CMS).

If a Beniversal® MasterCard® Prepaid Card is associated with my HRA:

- I authorize the issuance of a Beniversal MasterCard by a bank chosen by Benefit Resource. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Beniversal *Cardholder Agreement* and *My Beniversal Use of Card Promises* sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the *Agreement*, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature: _____ Date: _____ / _____ / _____

D. EMPLOYER SECTION *(to be completed by the employer)*

- **Effective date of enrollment/change:** _____ /_____ /_____
- ***Please select only one option:***

  ☐ New Enrollment: funding amount _____ ☐ per plan year ☐ Other_____

  ☐ Termination ☐ Resignation ☐ Retirement ☐ Change in hours ☐ Other_____
- **Health Insurance Coverage Code: ___ ___ ___ ___ ___ ___** ***This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NO MED.***