

HRA Enrollment Form

Company Name _____

Employee Name _____

Social Security Number _____ / _____ / _____ Effective Date ____ / ____ / ____

Date of Birth ____ / ____ / ____ Sex: Female ____ Male ____ Date of Hire ____ / ____ / ____

Home Telephone (_____) _____ - _____ Work Telephone (_____) _____ - _____

Street Address/PO Box _____

City _____ State _____ Zip _____

Full-Time _____ Part-Time _____ Seasonal (Less than 6 months per year) _____

Spouse's Employer _____ Are you covered under spouse's plan? Y ____ N ____

List of Dependents

Code	First Name	Last Name	Date of Birth	Social Security #
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____
			___/___/___	_____/_____/_____

Code: "S" = Spouse "C" = Child "A" = Adult Dependent

I authorize FlexSource to release my Health Reimbursement Account (HRA) claim information to the other adult dependents in my family (signatures below) in the event that there is a telephone inquiry made to FlexSource by that dependent.

Employee Signature _____ Date ____ / ____ / ____

Spouse or Adult Dependent Signature _____ Date ____ / ____ / ____