HRA Enrollment Form

For enrollment assistance, call Customer Care at 800-422-4661. Have your enrollment form, Client TASC ID, and company name available. Please print.

Client TASC ID	Employer Name		Social Security Number*	
Employee Last Name		First Name	Middle Initial	Gender
Employee Address		City	State	Zip
Date of Birth*	Date of Hire		Plan Type	
Initial Date of Coverage	Name of Insurance Carrier			
Participant Email Address		Participant Phone Number		

FOR DEPENDENT COVERAGE:**

Married? ❑ Yes ❑ No	Dependent Children? ❑ Yes ❑ No

If yes, list your spouse and dependent children below:

Last Name	First Name	Social Security Number*	Relationship to Employee	Date of Birth*	Gender

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses are covered under the group health plan sponsored by my employer, or another employer if allowed under my Plan. I understand that any amounts remaining in my account(s) not used for qualified expenses will be forfeited in accordance with current Plan provisions and tax laws.

Signature	Date

* Social Security and date of birth for employees and their dependents are required for HRA reporting purposes to the Centers for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Enrollment Forms without this required information will be returned for completion.

** Must provide spouse and/or dependent information if they are covered under group health plan and eligible for reimbursement under HRA. In order for any service rendered for your spouse or dependent(s) to be covered under this HRA Plan, the spouse or dependent receiving the service must be enrolled in your employer sponsored group health plan on the day the service was rendered. Some HRA Plans allow coverage under an employer sponsored group health plan offered by another employer. Check with your Benefits Advisor.