Qualified Small Employer 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

PARTICIPANT INFORMATION			
Last Name	First Name	Middle Initial	
Mailing Address	City	State	Zip
Email Address	Phone Number	Date of Birth	
Effective Date			

FOR DEPENDENT COVERAGE:	
Married? ☐ Yes ☐ No	Dependent Children? ☐ Yes ☐ No

If yes, list your spouse and dependent children below:

Last Name	First Name	Date of Birth	Relationship to Employee

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children or spouse for whom I will be claiming expenses and I are covered under a minimum essential health plan as defined by the Affordable Care Act (ACA) for all months of coverage under this HRA agreement. 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. I understand that failure to maintain minimum essential coverage for any month will make me subject to the ACA 'Individual Mandate Penalty' due under Section 5000A of the ACA, and will cause any reimbursement received from this HRA to be taxable income. I agree to only request reimbursement for authorized expenses per the plan documents.

Signature	Date