HRA Enrollment / Change Form

☐ **Enrollment** ☐ **Change** ☐ **Termination** **Employer:** _____

First Name:		**Last Name:**	
Social Security Number:		**Date of Birth:**	
Phone Number	☐ **Home** ☐ **Cell**	**Email:**	
Effective Date:		**Address:**	

Eligibilty:

Do you have an HSA?	☐ Yes ☐ No	**Are you contributing to it?**	☐ Yes ☐ No
Medicare Beneficiary?	☐ Yes ☐ No	**If Yes, Medicare ID**	
Health Plan Information Please indicate the health plan you are on:	☐ Company Sponsored Plan ☐ Medicaid ☐ Medicare ☐ Ind. VHC ☐ Spousal/Partner Plan ☐ Other: _____		

Dependent Information:

Last Name	First Name	SS #:	Date of Birth	Please choose where covered & note if different for each
				☐ Company Sponsored Plan ☐ Medicaid ☐ Spousal/Partner Plan ☐ Medicare ☐ Other: _____ ☐ Ind. VHC

Authorization I hereby elect to participate in my employer's HRA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I be required to refund the plan for the total expenses.

☐ I **ELECT** to participate in the Healthy Dollars HRA Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars HRA Plan

Employee Signature: _____ Date: _____

*** **For Accurate Enrollment Please Write Clearly** ***

October 2016

HEALTHY DOLLARS

DCA ENROLLMENT / CHANGE FORM

☐ **ENROLLMENT** ☐ **CHANGE** ☐ **TERMINATION** **EMPLOYER:** _____

First Name:		**Last Name:**	
Social Security Number:		**Date of Birth:**	
Phone Number	☐ **Home** ☐ **Cell**	**Email:**	
Effective Date:		**Address:**	

ELIGIBILTY:

Do you have an HSA?	☐ Yes ☐ No	**Are you contributing to it?**	☐ Yes ☐ No
Medicare Beneficiary?	☐ Yes ☐ No	**If Yes, Medicare ID**	
Health Plan Information **Please indicate the health plan you are on:**	☐ Company Sponsored Plan ☐ Medicaid ☐ Medicare ☐ Ind. VHC ☐ Spousal/Partner Plan ☐ Other: _____		

DEPENDENT INFORMATION:

Last Name	First Name	SS #:	Date of Birth	Please choose where covered & note if different for each
				☐ Company Sponsored Plan ☐ Medicaid ☐ Spousal/Partner Plan ☐ Medicare ☐ Other: _____ ☐ Ind. VHC

ELECTION:

	Annual Election	Deduction Per Pay Period	# of Pay Periods
Dependent Care Account			

Authorization I hereby elect to participate in my employer's DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses. ☐ I **ELECT** to participate in the Healthy Dollars Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars Plan

Employee Signature: _____ Date: _____

*** **For Accurate Enrollment Please Write Clearly** ***

October 2016