HRA Election Form

Company Name: _____

Employee Name _____

Mailing Address: _____

Email: _____ **Phone: _____**

Date of Birth: _____ SS#: _____

Date of Hire: _____ **Effective Date: _____**

Election of HRA Plan

☐ I elect to participate in the HRA Plan.

Please indicate your enrollment type (must match your medical plan enrollment):

☐ Single ☐ 2 Person ☐ Family

☐ I elect **NOT** to participate in the HRA plan.

Employee's Signature:	Date:
Accepted and Agreed to by the Authorized Delegate of the Plan Administrator:	Date: