HRA Election Form

Company Name: ____

Employee Name: ____

Mailing Address with City/State/Zip: ____

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

Please also complete the following for any enrolled dependents:

Spouse / Party to a Civil Union
or Domestic Partner Name: _____________________ Date of Birth: ____________ SS#: ________________ (M or F)
(Circle one) (Circle one)

Child Name: _________________________ Date of Birth: ____________ SS#: _________________ (M or F) (Circle one)

Child Name: _________________________ Date of Birth: ____________ SS#: _________________ (M or F) (Circle one)

Child Name: _________________________ Date of Birth: ____________ SS#: _________________ (M or F) (Circle one)

☐ 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:

NBM
Employee Benefits Simplified

9/2020