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: