This form is for Debit Card clients only.

KR______
SL______

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ENROLLMENT APPLICATION

Employer: ____

Last, First Name: _____________________________ SSN: _____________________

Date of Birth: ______________________ Coverage Effective Date: ______________

Address 1: ___________________________________ Address 2: ___________

City: ______________________ State: ______ Zip: ________________

Phone Number: ________________ Email address: ____________________________

Level of Coverage/Election Amount: ____

(***Example:*** *Single Coverage / $1000 - or if you only have one level, just enter the HRA election amount. Note: If your company pro-rates, please provide the pro-rated amount you wish to have set up.)*

Dependent Card Request (spouse/dependent*) Information:

***Only one card can be added at initial setup. Additional dependents/cards can be ordered from participants Consumer Portal.**

Dependent Name (Last, First): ____

Dependent SSN: _____________________ Dependent Date of Birth: ________________

Gender: ☐ Male ☐ Female Full Time Student: ☐ Yes ☐ No

Relationship (Indicate if they are Spouse or Dependent): _________________________

Submission to CPN:
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