This form is for Non-Debit Card clients only.

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 Information:

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:
Fax: 901.756.8322
Email: christina@cpnflex.com and katherine@cpnflex.com