This form is for Non-Debit Card clients only.

QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT (QSEHRA) 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: _____

Monthly Contribution Amount: _____

Submission to CPN:
Fax: 901.756.8322
Email: katherine@cpnflex.com