

# ENROLLMENT/CHANGE FORM HEALTH REIMBURSEMENT ACCOUNTS

(PLEASE PRINT CLEARLY)



2320 Brighton-Henrietta Townline Rd  
Rochester, NY 14623  
Phone: (800) 473-9595  
Website: [www.BenefitResource.com](http://www.BenefitResource.com)

## EMPLOYER:

### A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender:  Male  Female

Hire Date: / / Employee Status:  Full-Time  Part-Time

E-mail Address: \_\_\_\_\_

(Note: Benefit Resource will only use your e-mail address to communicate with you regarding your Plan.)

The purpose of this agreement is to authorize the employer to provide the employee with selected benefits. This agreement is designed to conform with Section 105(h) of the Internal Code.

### B. EMPLOYEE CERTIFICATION

I have received and read the printed material which explains my Plan and my options under it. I understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address, and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® MasterCard® is associated with my Health Reimbursement Account:

- I authorize the issuance of a Beniversal MasterCard by a bank chosen by Benefit Resource. I agree to use this card only for eligible medical expenses under the Plan for me or a qualifying individual and to be bound by all provisions of the Beniversal *Cardholder Agreement* and *My Beniversal Use of Card Promises* sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the *Agreement*, I may lose Beniversal Card privileges and will reimburse the Plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper follow-up requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such follow-up documentation to Benefit Resource upon request.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### C. EMPLOYER SECTION (to be completed by the employer)

- **Effective date of enrollment/change:** \_\_\_\_/\_\_\_\_/\_\_\_\_
- **Please select only one option:**
  - New Enrollment: funding amount \_\_\_\_\_  per Plan Year  other \_\_\_\_\_
  - Termination  Resignation  Retirement  Change in hours  Other \_\_\_\_\_
- **Health Insurance Coverage Code:** \_\_\_\_ This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter **NOMED**.

*Please return completed form to your employer.*