

ENROLLMENT/CHANGE FORM

Health Reimbursement Accounts

(PLEASE PRINT CLEARLY)



2320 Brighton-Henrietta Townline Rd
Rochester, NY 14623
Phone: 1-800-473-9595
Website: www.BenefitResource.com

EMPLOYER:

A. EMPLOYEE INFORMATION

Member ID:

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

Home Address: (Street) Apt #

(City) (State) (Zip Code)

Home Phone #: E-mail Address:

Hire Date: / / Birth Date: / / Gender: Male Female

Employee Status: Full-Time Part-Time

B. 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 _____

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 Revenue Code.

C. 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 I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my Account(s). I also understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

Signature: _____ Date: ____/____/____

Please return completed form to your employer.

The Employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.