



Health Reimbursement Arrangement (HRA) Enrollment Form

Employer Must Fill In	
Re-enrollment <input type="checkbox"/>	New <input type="checkbox"/> Change <input type="checkbox"/>
Effective Date	_____
1st Contribution Date	_____
Payroll Mode	W B S M Q
Division Code	_____

A. Personal Information (Be sure to print clearly, and provide all the information.)

Your Employer Name		Employer ID Number (Employer must fill-in)	
Your First Name	MI	Last Name	
Your Street Address <input type="checkbox"/> Check if this address is new within the last year			
City		State	ZIP Code
Your Member Number (Social Security Number or employer assigned number)	Date of Birth (MM/DD/YYYY)		Date of Hire (MM/DD/YYYY)

B. Contribution Information (Prepared by the Employer)

<input type="checkbox"/> Re-enrollment	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Changed Enrollment
<p>By signing this, you agree to the following statements:</p> <ul style="list-style-type: none"> Based upon the IRS list of eligible expenses, the Plan Sponsor may choose which expenses will be covered by the plan. My employer makes all contributions to the plan as noted in the plan document. Depending on the plan document, I may carry over any amount remaining in my HRA to a new plan year. Reimbursements can't exceed the contribution amount. This plan reimburses eligible expenses only after all my other plans have considered the expense. 		

C. Pre-Authorization for Direct Deposit (If you're enrolled in direct deposit already or don't wish to enroll, you can ignore this section.)

<input type="checkbox"/> I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements. This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement. A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION
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Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____

(PayFlex won't process without the Employer Signature)

PayFlex cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.

Please return completed form to:

Division of Retirement and Benefits
 P.O. Box 110203
 Juneau, AK 99811-0203
 Phone: (800) 821-2251 or (907) 465-4460
 Fax: (907) 465-3086