HRA ENROLLMENT FORM

122 Parish Drive
Wayne NJ 07470

Employer Name*: ________________________________

Employee Name*: ____________________ ____________ SS#*:_________- ______- __________
LAST FIRST

Home Address*: ________________________________ Date of Birth*: ______/_____/_______

City*: _________________State*:______Zip*:_________ Date of Hire: ______/_____/_______

Email Address*:________________________________

Marital Status*: ☐ S ☐ M ☐ D ☐ W Gender*: ☐ Male ☐ Female

Is this person now or has this person ever been enrolled in Medicare*? ☐ Yes ☐ No

If Yes, you must provide the Medicare claim number (HICN)*: ________________

FILL OUT INFO BELOW FOR ALL DEPENDENTS TO BE COVERED UNDER THE HRA

Spouse Name: ____________________ Male ☐ Female ☐ SS#: _____ - ____- ______ DOB: ____/____/____

Is this person now or has this person ever been enrolled in Medicare? ☐ Yes ☐ No

If Yes, you must provide the Medicare claim number (HICN): ________________

Dependent Name:____________________ Male ☐ Female ☐ SS#: _____ - ____- ______ DOB: ____/____/____

Is this person now or has this person ever been enrolled in Medicare? ☐ Yes ☐ No

If Yes, you must provide the Medicare claim number (HICN): ________________

Dependent Name:____________________ Male ☐ Female ☐ SS#: _____ - ____- ______ DOB: ____/____/____

Is this person now or has this person ever been enrolled in Medicare? ☐ Yes ☐ No

If Yes, you must provide the Medicare claim number (HICN): ________________

Dependent Name:____________________ Male ☐ Female ☐ SS#: _____ - ____- ______ DOB: ____/____/____

Is this person now or has this person ever been enrolled in Medicare? ☐ Yes ☐ No

If Yes, you must provide the Medicare claim number (HICN): ________________

☐ Waive HRA

____
EMPLOYEE SIGNATURE **DATE**

***Required** Fields

Please return this form to your Benefits/Human Resource administrator.

FOR EMPLOYER USE ONLY* - Must be completed or enrollment will not be processed.

Name of Health Plan______________________________

First Day of Coverage*:________/______/________ **HRA Amount*: $**__________________

Health Plan Status (check one)*: ☐ **Single** ☐ **Employee/Spouse** ☐ **Parent/Child** ☐ **Family**

Employer Representative Signature______________________________

Note: Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2001 (MMSEA) requires gente to report certain HRA enrollment data to the Centers for Medicare & Medicaid Services.

*Note: Partners, sole proprietors, owners of LLC and 2% or more owners of sub chapter S corporation are not permitted to participate in an HRA program.