Enrollment/Change Form

HEALTH REIMBURSEMENT ACCOUNT (HRA)

BRi — An Inspira Financial Solution

Employer

Effective Date of Enrollment *(MM/DD/YYYY)*

Employee Name - *First Name, Middle Initial, Last Name*

Hire Date *(MM/DD/YYYY)*

Member ID *(set by employer. Typically an employee ID or SSN.)*

Birth Date *(MM/DD/YYYY)*

Street or PO Box

Email Address

City State ZIP

Phone Number

Employment Status:

☐ Full Time ☐ Part Time

Social Security Number (SSN)

Please enter your dependent information below, or check here if you do not have any: ☐

Add: ☐ Remove: ☐ SSN:

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child

Dependent's Name:

Dependent's Date of Birth:

Medicare Health Claim Number:

Effective Date of HRA Coverage:

Please check all that apply:

☐ End Stage Renal Disease (ESRD)

☐ Disabled

☐ Current Medicare Beneficiary

☐ Covered by a group health insurance plan *(if required by your plan)*

Add: ☐ Remove: ☐ SSN:

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child

Dependent's Name:

Dependent's Date of Birth:

Medicare Health Claim Number:

Effective Date of HRA Coverage:

Please check all that apply:

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Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child

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HEALTH REIMBURSEMENT ACCOUNT (HRA)

PLEASE CERTIFY THE FOLLOWING:

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 Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual* and must not be reimbursed from any other source. I also understand that if I or my spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a general Health Reimbursement Account (HRA). If the HRA is an HSA-compatible plan (e.g. limited purpose, post-deductible), HSA contributions can be made.

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. I verify that the information detailed above is true and accurate. I understand that certain information being requested is necessary to comply with the mandatory Section 111 reporting and will be sent to The Centers for Medicare & Medicaid Services (CMS).

If a Beniversal® Prepaid Mastercard® is associated with my HRA:

- I authorize the issuance of a Beniversal Card. 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 Cardholder Agreement and 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 Cardholder Agreement, my account may be suspended and I 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 followup 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 followup documentation to Benefit Resource upon request.

Signature _____ Date *(MM/DD/YYYY)* _____

**Effective for plan years that begin on or after January 1, 2017, reimbursement of expenses from your HRA can only be for you, your spouse and/or your eligible dependents who are covered under a group health insurance plan as outlined in your Plan Highlights.*

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

EMPLOYERS ONLY - This section must be complete for employee to be enrolled

Effective date of enrollment change: _____

Account Type: ☐ Health Reimbursement Account

☐ Limited Health Reimbursement Account
(Reimburses dental, vision and/or post-deductible expenses as allowed by the plan. Participants cannot receive contributions to this account if contributions are being made to a Health Reimbursement Account.)

Please select only one of the following options:

☐ New Enrollment, funding amount: $ _____ ☐ Per plan year ☐ Other: _____

☐ Termination ☐ Resignation ☐ Retirement ☐ Change in hours ☐ Other: _____

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.

EMPLOYERS: Retain this document for your records; do NOT send it to BRI. The required information should be sent to BRI via your normal file exchange process.