Health Reimbursement Arrangement
HRA Enrollment Form

HRA Type: Standard ☐ **QSEHRA** ☐ **Other** ☐ **Hire Date:** _____ **Effective Date:** _____

REQUIRED INFORMATION

Company Name:		**Division:**		
Employee First Name:	**MI:**	**Employee Last Name:**		
Social Security Number:		**Address:**		
Email Address:		**City:**	**State:**	**Zip:**
Phone Number:		**Day Time Phone Number:**		
Birth Date:		**Gender:**		

Funding: Single ☐ **Two-Person** ☐ **Family** ☐ **Other:** _____

DEPENDENTS TO BE COVERED

First Name	MI	Last Name (If Different)	S.S. # (Required)	Date of Birth	M/F	Relationship

AUTHORIZATION OR WAIVER OF PARTICIPATION

I request to participate in the benefits indicated above. I understand that my elections indicated are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan. If I have waived participation, I understand that I may not join the Plan until the start of the next plan year.

Under penalty of perjury, I agree to use the debit card solely for the purchase of eligible expenses. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account. I understand that these expenses cannot be claimed on my income tax return. By signing this form, I hereby authorize my employer to deduct any ineligible expenses paid for with the **EBS Card** from my paycheck. I understand that any unauthorized use may result in the suspension of my the **EBS Card**.

☑ **I elect to participate in the EBS HRA plan**
☐ **I *do not* elect to participate in the EBS HRA plan**

By signing below, I hereby authorize the release of claim information to my employer, their broker, and EBS:

Employee Signature:_____ Date: _____

Employee Benefit Systems - 214 North Main Street, Burlington, IA 52601
Phone: 800-373-1327 - Fax: 888-511-3743 - Email: mybenefits@ebs-tpa.com