HRA Enrollment / Change Form

☐ Enrollment ☐ Change ☐ Termination Employer: _____

First Name:		**Last Name:**	
Social Security Number:		**Date of Birth:**	
Phone Number	☐ Home ☐ Cell	**Email:**	
Effective Date:		**Mailing Address** *(please include city, state & zip code)*:	

Dependent Information:

Last Name	First Name	SS #:	Date of Birth

*Note- To participate in the HRA plan, you must be enrolled in a health plan with minimum essential coverage through an employer. Individual health plans are not HRA compatible. You also may not *contribute* to a Health Savings Account without notifying Healthy Dollars as your HRA plan may need to be limited to dental and vision expenses only.

Authorization I hereby elect to participate in my employer's HRA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses.

☐ I **ELECT** to participate in the Healthy Dollars HRA Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars HRA Plan

Employee Signature: _____ Date: _____

*** **For Accurate Enrollment Please Write Clearly** ***

November 2018