AMERICAN BENEFITS GROUP

HEALTH REIMBURSEMENT ARRANGEMENT - ENROLLMENT FORM

You must complete and return this form. Please print.

Name: _____ Social Security #: _____

Home Address: _____ Email: _____

City, State, Zip: _____ Phone: _____

Date of Birth: _____ Gender _____ Employer/Division: _____

As a Participant in my Employer's Health Plan I understand that I am eligible to receive certain reimbursements through the Company's Health Reimbursement Arrangement (HRA); I have elected the following coverage under my Employer's Health Plan:

HEALTH INSURANCE ELECTION: SINGLE ☐ DOUBLE ☐ FAMILY ☐

Insurance Plan: _____ HRA Amount: _____

Effective Date of Coverage: _____

I understand that the employer funded HRA account is provided to reimburse eligible deductible expenses under my High Deductible Health Insurance Plan and other qualified medical expenses as allowed by my employer per the HRA plan document. All other expenses are my responsibility and will not be reimbursable to me through my HRA account.

Please Complete the Following Dependent Information

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#: _____ Relationship: Spouse ☐ Domestic Partner ☐ Gender: M ☐ F ☐

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#: _____ Relationship: Child ☐ Gender: M ☐ F ☐

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#: _____ Relationship: Child ☐ Gender: M ☐ F ☐

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#: _____ Relationship: Child ☐ Gender: M ☐ F ☐

_____ _____
Employer Signature Date

Fax Toll Free: 877-723-0147 or email to processing@amben.com

No Fax Machine? Mail to: American Benefits Group
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