Health Reimbursement Arrangement Enrollment Form

PRIMEPAY

ELIGIBILITY DATE: _____

(877) 769-3539 | TO BE COMPLETED BY EMPLOYEE AND GIVEN TO EMPLOYER.

RESET FORM

Employee Information (Please print clearly) ☐ PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE

NAME (LAST, FIRST, MIDDLE)[5]		SOCIAL SECURITY NUMBER	BIRTHDATE	
STREET ADDRESS		**CITY**	**STATE**	**ZIP CODE**
EMPLOYER		**WORK #**	**PHONE** ☐ Home ☐ Mobile	
EMAIL		**GROUP HEALTH PLAN NAME**	**HIRE DATE**	
ISSUE CARD*	**ESRD[3]**	**HICN[4]/MEDICARE ID**	**SEX**	
☐ Yes ☐ No	☐ Yes ☐ No		☐ Male ☐ Female ☐ Other	

ALL FIELDS ARE REQUIRED DUE TO MEDICARE MANDATORY REPORTING. LIST ALL MEMBERS WHO ARE COVERED UNDER THIS PLAN.

SELECT THE COVERAGE ELECTED WITH YOUR EMPLOYER: ☐ Single ☐ EE + Spouse ☐ EE + Child/Children ☐ Family

ISSUE CARD* Y/N?	BENEFICIARY LAST NAME[5]	BENEFICIARY FIRST NAME[5]	RELATIONSHIP CODE[1]	BENEFICIARY SSN	BIRTHDATE	SEX	ESRD[3] Y/N	HICN[4] (MEDICARE ID)	HRA COVERAGE ELIGIBIILTY DATE

***If applicable**

1-Relationship
01=self/policyholder
02=spouse or common law spouse
03=child
20=domestic partner
04=other

3-ESRD End Stage Renal Disease
Permanent kidney failure requiring dialysis or a kidney transplant.

4-HICN Health Insurance Claim Number (Medicare ID)
This is required if SSN is not provided or if the active covered individual is under 45 years old and is entitled to (covered under) Medicare due to ESRD or a disability.

5-Name
Report the name as it appears on the individual's SSN or Medicare Card.

I confirm that I am eligible to participate in the Health Reimbursement Account (HRA). I understand that I can only use this account for eligible expenses as governed by the IRS and my plan documents and if I receive a debit card it will only be used to pay for eligible expenses. I understand that participation in the HRA is irrevocable for the plan year and may only be changed if i have a qualifying event. I understand that the plan administrator may modify/cancel these plans at any time. I understand that I must retain all receipts for purchases and services rendered, and agree to provide them upon request. For the purpose of substantiating expenses under my HRA, I hereby authorize the release of Protected Health Information (PHI) for myself and any qualifying dependents. This information will not be discussed with anyone other than my providers, employer, PrimePay Representatives/affiliates, or a person authorized by my employer. I confirm that to the best of my knowledge all of the information provided is correct.

EMPLOYEE SIGNATURE:_____ **DATE:**_____ **EMPLOYER INITIALS:**_____

If you require further assistance, please visit support.primepay.com.