



PrimeFlex—(877) 769-3539

Health Reimbursement Arrangement Enrollment Form

To be completed by employee and given to employer.

Office Use Only	
Date Processed:	/ /
Processed by:	Client #:

Entry (Effective) Date: _____

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

Name ⁵ : (Last, First, Middle)		SSN:	Date of birth:
Street:	City:	State:	Zip:
Employer:			Work #:
Email:			Mobile (Includes SMS Updates)
Group Health Plan Name:			Hire Date:
Issue Card*: Y/N	ESRD ³ : Y/N	HICN ⁴ /Medicare ID:	Sex ² :

All fields are required due to Medicare mandatory reporting. **PLEASE LIST ALL MEMBERS WHO ARE COVERED UNDER THIS PLAN.**

Please 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	Date of Birth	Sex ²	ESRD ³ Y/N	HICN ⁴ (Medicare ID)	HRA Coverage Eligibility Date

1—Relationship

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

*if applicable

2—Sex

0=unknown
1=male
2=female

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 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 Health Reimbursement Account, 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, PrimeFlex/affiliates, or 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: _____

