

HRA Enrollment/Change/Termination Form

Fax completed form to: 704-375-1599 or 1-800-598-6844
 Questions/Assistance: 704-334-5517 or 1-800-598-6843



Company Name: _____	Effective Date: _____
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A. Indicate Action (check all that applies):

<input type="checkbox"/> Add New Enrollee: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> Change/Correct: <input type="checkbox"/> Coverage Level <input type="checkbox"/> Effective Date <input type="checkbox"/> Personal Information <input type="checkbox"/> Other: _____	Add Coverage – Indicate Event: <input type="checkbox"/> New Hire <input type="checkbox"/> Return from Leave <input type="checkbox"/> Addition of Dependent(s): <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption or Placement for Adoption <input type="checkbox"/> Judgment/Decree/QMCSO <input type="checkbox"/> Other: _____	Terminate Coverage - Indicate Event: <input type="checkbox"/> Terminate Employment/Layoff <input type="checkbox"/> Reduction in Hours/Leave of Absence <input type="checkbox"/> Death of Employee <input type="checkbox"/> Loss of Spouse/Dependent(s): <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Legal Separation <input type="checkbox"/> No Longer Legal Dependent <input type="checkbox"/> Obtained Other Coverage: <input type="checkbox"/> Enrolled in Other Group Coverage <input type="checkbox"/> Qualified for Medicare/Medicaid <input type="checkbox"/> Other: _____
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B. Coverage Information:

Indicate Coverage Level: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family	Plan Type (If Applicable) <input type="checkbox"/> Option 1 or Plan A <input type="checkbox"/> Option 2 or Plan B <input type="checkbox"/> Other: _____	Prorated Benefits (If Applicable) <small>If your company is prorating the HRA benefit for mid-year new hires, please indicate the exact dollar amount of the HRA benefit as of the effective date:</small> Per Individual \$ _____ Per Family \$ _____
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C. Employee Information:

Last Name	First Name	MI	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Mailing Address			City	State	Zip
E-Mail Address			Phone	Dept.	Enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide HICN*

D. Dependent Information:

First Name/Last Name	Social Security Number	Date of Birth	Gender	Enrolled in Medicare?
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide HICN*
<small>Is Spouse a Domestic Partner? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, contact Elkin & Associates at (800) 598-6843 for information regarding IRS guidelines)</small>				
Dependent #1			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide HICN*
Dependent #2			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide HICN*
Dependent #3			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide HICN*
Dependent #4			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide HICN*

E. Signatures:

I hereby certify the above information is correct:

Employee Signature: _____ **Date Signed:** _____

Human Resource Approval:

Authorized Signature: _____ **Date Signed:** _____

*HICN is the Medicare eligibility number. In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Elkin & Associates is required to report HRA eligibility to the federal government. **Note: If Medicare enrolled individual is under age 65, please indicate if the individual is entitled to Medicare due to End-Stage-Renal-Disease (ESRD).**

Official Use Only	Date Received	Date Entered	Entered By	Date COBRA Offer Mailed
CIS Form				N/A
COBRA				