PRIMEPAY®

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PrimeFlex—(877) 769-3539

Health Reimbursement Arrangement Enrollment Form

To be completed by employee and given to employer.

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:				Home #:
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: _____