Health Reimbursement Account Enrollment Form

Employer Name: ____

Participant Name (First, MI, Last): ______________________________________

Social Security Number:_____-_______-____________ Phone Number: (_______) ______________

Address: ____

City, ST, ZIP: ____

Date of Birth:_______/________/__________Date of Hire:_________/_______/__________

Email Address: ______________________________________

☐ I agree to receive communications regarding my HRA via email from Lifetime Benefit Solutions.

Spouse/Dependents Eligible Under Medical Plan Information (attach additional pages if necessary)

☐ I do not have a spouse or dependents

Name	Social Security Number	Date of Birth	Gender	Relationship

Direct Deposit Election (Complete this section if you want Direct Deposit of your reimbursements)

Type of Account (Check one): ☐ Checking ☐ Savings

Name of Bank: ____

Transit ABA Routing #:____________________Account #: ________________________

To Be Completed by the Employer

Annual Contribution Amount	$

☐ New Hire ☐ Open Enrollment Effective Date: ______________

- Keep copy of Enrollment Form for your records
- Forward copy of Enrollment Form or provide data on a file to Lifetime Benefit Solutions