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HEALTH REIMBURSEMENT ACCOUNT

Town of Westford, MA HRA Enrollment Form

***Address*: 111 Charles St, *Manchester*, NH 03101**
***E-Mail*: Enrollmentdepartment@hrcts.com**

A. *Employee Information*

Please Print Clearly! Instructions on Back

Name: _____ Social Security Number (Required): _____

Home Address:
Check if New: ☐ _____

City: _____ State: _____ Zip Code: _____ Day Phone: _____

E-mail Address: _____ Date of Birth: _____

B. *Benefit Plan* Coverage Information

1. Health Reimbursement Account

(Select your coverage level below)

School Division

Coverage Tier: ☐ Individual ☐ Ind +1 ☐ Family

2. Dependent Information

(List all of your eligible dependents that are covered under your plan) *

Full Name	Social Security Number	Date of Birth	Relationship to Employee
1.			___Spouse ___Child
2.			___Spouse ___Child
3.			___Spouse ___Child
4.			___Spouse ___Child
5.			___Spouse ___Child
6.			___Spouse ___Child

**Please Note: Due to the Medicare Secondary Payer Group Health Plan reporting requirements mandated by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2001 (MMSEA) (P.L. 110-173), we are required to report certain information to the Center of Medicare Services, therefore, SSN and DOB are required information on this form and we will not be able to enroll you in this benefit without this important information.*

C. *Direct Deposit Authorization*

If you would like reimbursements to be direct deposited to your bank account (rather than receiving paper checks) fill out the information below EACH PLAN YEAR AND attach a voided check.

Bank Name:
(See #1 on sample)

☐ Checking Account
☐ Savings Account

Routing Number - 9 digits (See #2 on sample):

Account Number (See #3 on sample): _____

SAMPLE

D. *Signatures* By signing below, I agree to all of the Terms and Conditions stated on the opposite side of this form.

Employee Signature (required):		Date:	
Employer Acceptance (required):		Effective Date:	

Enrollment Form Instructions

Section A	**EMPLOYEE INFORMATION** - Please print your name and complete address clearly. Your phone number and e-mail address will be used only to communicate with you with regards to this plan. It will not be distributed to any other organization or used for marketing purposes in any way. Statements of your account balance and activity will be sent via e-mail whenever possible. Please understand that this is an employee account and due to federal and state laws we cannot release detailed information to anyone other than the participant, this also includes your spouse and/or dependent(s). Please contact our office for further information.
Section B	**HEALTH REIMBURSEMENT ACCOUNT PLAN PREVISIONS** **1.** Health Reimbursement Account - Please select the coverage tier that you are enrolled in. **2.** Dependent Information - Please Note: Due to the Medicare Secondary Payer Group Health Plan reporting requirements mandated by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2001 (MMSEA) (P.L. 110-173), we are required to report certain information to CMS therefore, SSN and DOB are required information on this form and we will not be able to enroll you in this benefit without this important information.
Section C	**Direct Deposit Authorization** - Claims that are faxed, mailed or filed on-line are normally reimbursed by sending you a paper check. If you would like your reimbursements sent directly to your checking or savings account via Direct Deposit, fill out this section and attach a voided check (for checking) or deposit slip (for savings). Confirmations are sent via email and will show current transaction information as well as available funds in the account.
Section D	**Signatures** - After you have completely filled out this form and carefully read the following Terms and Conditions please sign and date then return the enrollment form to the HR office as applicable. Employers must review the elections and sign that the employee meets the eligibility requirements.

Health Reimbursement Account Plan Terms and Conditions

I UNDERSTAND THAT:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I understand that this Plan is setup to reimburse expenses incurred by my legal dependents or myself only. *Domestic/Civil Union Partners are <u>not</u> IRS eligible dependents in most cases.*
- Health Reimbursement Accounts (HRA) will be reimbursed up to the annual amount (minus previous payments).