

HRA Additions Form

Employer Name: _____

Employee #1 Name: _____		SSN: _____	Date of Birth: _____
Status: <input type="checkbox"/> Addition	Effective Date: _____	<input type="checkbox"/> COBRA Reinstatement	Effective Date: _____
Address: _____		City: _____	State: _____ Zip Code: _____
Phone Number: _____		Email Address: _____	
HRA Tier: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Family <input type="checkbox"/> Other			
Date of Hire _____			

Employee #2 Name: _____		SSN: _____	Date of Birth: _____
Status: <input type="checkbox"/> Addition	Effective Date: _____	<input type="checkbox"/> COBRA Reinstatement	Effective Date: _____
Address: _____		City: _____	State: _____ Zip Code: _____
Phone Number: _____		Email Address: _____	
HRA Tier: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Family <input type="checkbox"/> Other			
Date of Hire _____			

*MSP Reporting Requirements: Please provide Employee Spouse and all Dependent information if participant/spouse is 45 years of older and/or on Medicare. Please complete MSP reporting section below.

MSP Reporting Section

In this section of the form, please fill in Spouse/Dependent information required for MSP Reporting.

Employee #1 Name: _____		Spouse Name: _____		Date of Birth: _____
SSN: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Dependent #1 Name: _____		Date of Birth: _____		
SSN: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Relationship: _____
Dependent #2 Name: _____		Date of Birth: _____		
SSN: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Relationship: _____
Employee #2 Name: _____				
Spouse Name: _____		Date of Birth: _____		
SSN: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Dependent #1 Name: _____		Date of Birth: _____		
SSN: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Relationship: _____
Dependent #2 Name: _____		Date of Birth: _____		
SSN: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Relationship: _____

If additional space is needed for Dependent information, please use another FlexHRA Additions Form.

Plan Administrator Signature: _____ Date: _____

Please send all completed forms and documentation to Flexible Benefit Service Corporation.

GO PAPERLESS!

You can login to your account at flexiblebenefit.com and manage eligibility transactions online without needing to complete any paper forms. Get started today!

HA953239A