HEALTH REIMBURSEMENT ACCOUNT

(To be submitted by the employer.)

Please Note: *This form must be completed for all participants who intend to enroll for each new plan year. All fields designated with an asterisk (*) must be completed in order for enrollments to be accepted.*

ENROLLEE DEMOGRAPHIC INFORMATION

First Name*: _____ MI: _____ Last*: _____

Member ID (which may be your SSN)*: _____ DOB* (*MM/DD/YYYY*): _____

Mailing Address*: _____

City*: _____ State*: _____ Zip*: _____

Email: _____ Gender*: M ☐ F ☐

Are you now, or have you ever, been enrolled in Medicare?* Yes ☐ No ☐

If "Yes," you must provide your Medicare Claim Number (HICN): _____

*Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires Ameriflex to report certain HRA enrollment data to the Centers for Medicare & Medicaid Services.

SECTION TO BE COMPLETED BY EMPLOYER

Employer Name*: _____

HRA Plan Year* (*MM/DD/YYYY*): _____ to (*MM/DD/YYYY*): _____

HRA Coverage Tier*: Single ☐ Enrollee and Spouse ☐ Enrollee and Child ☐ Family ☐

Enrollee Hire Date* (*MM/DD/YYYY*): _____ Enrollee Effective Date* (*MM/DD/YYYY*): _____

Is the coverage amount to be prorated? Yes ☐ No ☐

HRA Coverage Amount*: Tier 1: $ _____ Tier 2 (*if applicable*): $ _____

Is Ameriflex tracking the employee's out-of-pocket responsibility? Yes ☐ No ☐

☐ By checking this box, I certify that I am the individual whose name appears below. Furthermore, I understand that the Plan Administrator may reduce or cancel my Health Reimbursement Account or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code or for any other reason within its discretion if such modification is legally allowable. I certify that: All individuals covered by the Health Reimbursement Account are represented accurately on this enrollment form.

Employee Signature: **Date:**

Please sign and return this form to your HR department.

Employer Signature: **Date:**

This form is to be sent by the employer directly to their dedicated Client Experience Specialist or DL-CSX@myameriflex

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Name of Enrollee: _____

DEPENDENT INFORMATION

Please note that AmeriFlex Convenience Cards will only be issued to a dependent if: They are at least 18 years of age and it is confirmed below that they are to receive a card.

Spouse/Partner:

First Name*: _____ MI: _____ Last Name*: _____

SSN*: _____ DOB* (*MM/DD/YYYY*): _____ Gender*: Male ☐ Female ☐

Mailing Address (if different than enrollee)*: _____

City*: _____ State*: _____ Zip*: _____

Issue Card? Yes ☐ No ☐ Are you now, or have you ever been enrolled in Medicare?* Yes ☐ No ☐

If "Yes," you must provide your Medicare Claim Number (HICN): _____

Dependent Child:

First Name*: _____ MI: _____ Last Name*: _____

SSN*: _____ DOB* (*MM/DD/YYYY*): _____ Gender*: Male ☐ Female ☐

Mailing Address (if different than enrollee)*: _____

City*: _____ State*: _____ Zip*: _____

Issue Card? Yes ☐ No ☐ Are you now, or have you ever been enrolled in Medicare?* Yes ☐ No ☐

If "Yes," you must provide your Medicare Claim Number (HICN): _____

Dependent Child:

First Name*: _____ MI: _____ Last Name*: _____

SSN*: _____ DOB* (*MM/DD/YYYY*): _____ Gender*: Male ☐ Female ☐

Mailing Address (if different than enrollee)*: _____

City*: _____ State*: _____ Zip*: _____

Issue Card? Yes ☐ No ☐ Are you now, or have you ever been enrolled in Medicare?* Yes ☐ No ☐

If "Yes," you must provide your Medicare Claim Number (HICN): _____

Enrollee Signature: **Date:**

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