HRA ENROLLMENT/CHANGE/TERMINATION FORM

Please use this form to communicate when an employee is eligible to begin, change and/or end participation in the Section 105 Health Reimbursement Arrangement (HRA). Refer to your Plan Document to determine specific eligibility requirements and any COBRA responsibilities upon termination.

Employer Name	**Plan Effective (Start) Date** Month Day Year | |	**Plan End Date** Month Day Year | |
Employee's First **Middle Initial** **Last Name** ☐ Female ☐ Male	**Social Sec#**	**Date of Birth** Month Day Year | |
Home Address **City** **State** **Zip**		**Hire Date** Month Day Year

Type of Coverage (check one below as applicable):	***Coverage Start Date***	***Change Date***
☐ Single _____	_____	_____
☐ Employee plus One _____	_____	_____
☐ Family _____	_____	_____
☐ _____ Other _____	_____	_____
(Record category title above)		

Dependent Name(s) **(Use separate page if more space is needed. Last name only if different than employee.)**	**Soc Sec # or Medicare #**	**Date of Birth**	**Relationship (Spouse or Child)**	**Adult** Child (Y or N)**	**Gender (M/F)**	**End Stage Renal Disease or Kidney Transplant (Y or N)**	**Change Reason (if applicable)**
1.			**Self**				
2.			**Spouse**				
3.			**Child**				
4.			**Child**				
5.			**Child**				
6.			**Child**				

****The fair market value of HRA coverage for an adult child who is not a dependent for purposes of income tax filing may be reported as income and subject to the applicable income taxes.**

TERMINATION SECTION

Employer must complete this section **IMMEDIATELY** and submit it to Benefits Design Group, Inc. when the participant terminates his/her employment or ceases to satisfy the eligibility requirements under the Plan.

Employee Name: **Soc Sec #:**	**Termination Date:**
Check as applicable: ☐ Voluntary Termination or ☐ Involuntary Termination Due to Gross misconduct ☐ Yes ☐ No	
COBRA Eligible (check one): ☐ Yes ☐ No	
If Yes, was COBRA notice sent (check one)? ☐ Yes ☐ No	
COBRA Elected (check one)?: ☐ Yes ☐ No (Please note: HRA COBRA premiums may be in addition to the Health Plan COBRA premiums. Please refer to your Plan Document.)	

EMPLOYER SECTION (required for both additions and terminations)

Authorized Employer Signature:	**Date:**

Please complete, sign this form and forward to us via mail or fax to the address below.

Benefits Design Group, Inc. PO Box 370 Onalaska WI 54650
Phone: 1-800-342-8235 Fax Number: 1-608-781-4576

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