HEALTH REIMBURSEMENT ARRANGEMENT
ENROLLMENT/CHANGE/TERMINATION FORM

1. Name:_____ Soc. Sec._____-_____-_____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Marital Status:_____ Sex:_____

2. Action to Be Taken:
[ ] Enroll in HRA Plan [ ] Waive HRA Participation [ ] Change In Covered Dependents

3. I select the following coverage option:
[ ] Employee Only [ ] Employee & Spouse [ ] Employee & Child [ ] Employee & Family

4. List eligible family members for Health Reimbursement Arrangement coverage:

Relationship	Name	Sex	Date of Birth
Self	_____	_____	_____
Spouse	_____	_____	_____
Dependent	_____	_____	_____
Dependent	_____	_____	_____

5. Authorization and Agreement

I have read the information describing the Health Reimbursement Arrangement Summary Plan Description and agree to abide by the terms of the Plan Document. I recognize I must submit signed documents and a Reimbursement Request Form to the Plan's Administrator for the reimbursement of qualified expenses, as determined by the Plan Administrator. I recognize that any expenses I submit for reimbursement must not be covered by any other source such as insurance. I understand that I will have three months in which to submit qualified expenses following the close of a Plan Year, or upon termination of participation.

Employee's Signature_____ Date:_____

Received by:_____ Date:_____

Effective Date:_____