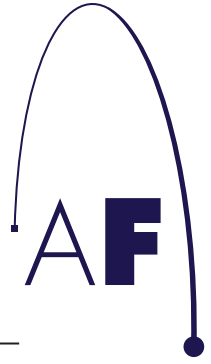




HEALTH REIMBURSEMENT ACCOUNT



HRA ENROLLMENT FORM

Company Name: _____

Employee Name: _____ Telephone: _____ - _____ - _____

Employee Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Employee Social Security Number: _____ - _____ - _____ Plan Year: _____ through _____

Date of Birth ____/____/____ Date of Hire ____/____/____ Effective Date ____/____/____

Is this person now, or has this person ever been enrolled in Medicare*? Yes No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

Employee's Health Reimbursement Account Allocation

First Date of Coverage: _____ HRA Amount: \$ _____

Health Plan Status (check one): Single Employee/Spouse Parent/Child Family

Additional Cards (only applicable if your employer has chosen this option)

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, they must be over the age of 18 and meet the IRS eligibility guidelines.

Spouse Name: _____ Soc. Sec. Number: _____ Date of Birth: _____

Address to issue card (if different than participant): _____

Telephone: _____ Is this person now, or has this person ever been enrolled in Medicare*? Yes No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

Dependent Name: _____ Soc. Sec. Number: _____ Date of Birth: _____

Issue additional AmeriFlex Convenience Card® to this dependent? Yes No Telephone: _____

Address to issue card (if different than participant): _____

Is this person now, or has this person ever been enrolled in Medicare*? Yes No

If "Yes," you must provide this person's Medicare Claim Number (HICN): _____

Dependent Name: _____ Soc. Sec. Number: _____ Date of Birth: _____

Issue additional AmeriFlex Convenience Card® to this dependent? Yes No Telephone: _____

Address to issue card (if different than participant): _____

Is this person now, or has this person ever been enrolled in Medicare*? Yes No

If "Yes," you must provide this person's 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.

I understand that: The plan administrator may reduce or cancel my Health Reimbursement Plan 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.

Please return this signed agreement to your Benefits/Human Resource administrator.

Employee Signature _____ Date _____