KCTCS
2014 HRA Enrollment Form

You will be making elections for the **1/1/2014** through **12/31/2014** Plan Year. After completing this form, please sign, date, and **return it to your Human Resources Department on or before the end of your enrollment period.**

PARTICIPANT INFORMATION – *Please Print Legibly*			
SSN	Gender ☐ Male ☐ Female	Medicare HIC # (If enrolled in HRA & Medicare)	
Last Name		First Name	
Birth Date		Marital Status ☐ Married ☐ Single	
Street Address			
City		State	Zip
Primary Phone ( )		Secondary Phone ( )	
Email			
Coverage Level (If applicable) ☐ Single ☐ Employee+Child(ren) ☐ Employee+Spouse ☐ Family			

DEPENDENT INFORMATION (FOR CMS REPORTING PURPOSES)			
My Dependents:			
Spouse Name	DOB / /	Spouse SSN	Medicare HIC#
Child Name	DOB / /	Child SSN	Medicare HIC#
Child Name	DOB / /	Child SSN	Medicare HIC#
Child Name	DOB / /	Child SSN	Medicare HIC#
Child Name	DOB / /	Child SSN	Medicare HIC#

PLAN INFORMATION – *Please Print Legibly*		
Health Reimbursement Arrangement (HRA) Reimbursement of expenses as explained in your enrollment brochure. **ONLY ELECT THIS BENEFIT IF YOU ARE WAIVING MEDICAL COVERAGE**	☐ Yes ☐ No	*If you do not wish to provide the required dependent information above, you must complete the **CMS Data Collection Form** & return it to HR.*
Direct Deposit – Used for paper/online claims for reimbursement to your bank account. *Note: In the event that your direct deposit transaction is returned, Chard Snyder reserves the right to collect a $25 processing fee.* Nine Digit Routing Number (*Include ALL Zeros*): _____ Bank Account Number (*Include ALL Zeros*): _____ Bank Name: _____	☐ Yes ☐ No	☐ Checking ☐ Savings

PARTICIPANT AUTHORIZATION	
I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all the authorizations & acknowledgements provided by Chard Snyder for each plan elected above on the second page of this form. I also acknowledge the receipt of the HIPAA Privacy Notice provided at open enrollment and/or provided on the Chard Snyder website (www.chard-snyder.com).	
Signature	Date / /

HR USE ONLY – *Must be completed by HR Rep prior to sending to Chard Snyder*		
Employee Effective Date / /	1st Contribution Date / /	Initials

PARTICIPANT ACKNOWLEDGEMENTS & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate in the plan(s).

HRA – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me.
- Funds available in the HRA account may be used for eligible expenses deemed permissible under Section 213 of the Internal Revenue Code, provided that my employer has not chosen to limit the HRA to certain items.
- Eligible expenses must be incurred by an eligible participant to be considered for reimbursement (the date of service, not the billing date, must occur while a participant is in the Plan).
- Out-of-pocket expenses cannot be itemized and deducted again on an IRS Form 1040 or reimbursed again through any other benefit programs.
- I understand that I am required to save all receipts for purchases in case I should be audited by the IRS.
- I hereby understand the information on this form and authorize Chard Snyder to complete my request.
- I must supply proof that I am covered under another health insurance plan to be eligible for enrollment in the HRA

DIRECT DEPOSIT – ACKNOWLEDGEMENT & AUTHORIZATION

I understand that:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and / or debit the same to such account.
- Direct deposit of my reimbursements shall commence within 4 weeks of receipt of this form.
- My direct deposit may be terminated per any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, or cancellation of direct deposit by my employer.
- I hereby understand the information on this form and authorize Chard Snyder to complete my request.