ENROLLMENT/CHANGE FORM
HEALTH REIMBURSEMENT ACCOUNTS
(PLEASE PRINT CLEARLY)

Please remit form to: 100 Quentin Roosevelt Blvd, Suite 403
Garden City, NY 11530
Phone (516) 289-9013
Fax (516) 777-9076
claims@fbanational.com

EMPLOYER:

A. EMPLOYEE INFORMATION

Social Security Number: Medicare Health Claim Number (HICN): *(if applicable)*

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Mobile #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time ☐ Retired

Email Address: _____
(Note: FBA will only use your email address to communicate with you regarding your plan.)

Please check all that apply:

☐ End Stage Renal Disease (ESRD)

☐ Disabled

☐ Current Medicare Beneficiary

☐ *Covered by a group health insurance plan *(if required by your plan)*

The purpose of this agreement is to authorize the employer to provide the employee with selected benefits. This agreement is designed to conform with Section 105(h) of the Internal Revenue Code.

B. DEPENDENT INFORMATION ☐ *Check here if you do not have any eligible dependents. Proceed to Section C.*

☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____

Last Name: _____ First Name: _____ (MI): ____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:
☐ End Stage Renal Disease (ESRD)
☐ Disabled
☐ Current Medicare Beneficiary
☐ *Covered by a group health insurance plan *(if required by your plan)*

☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____

Last Name: _____ First Name: _____ (MI): ____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:
☐ End Stage Renal Disease (ESRD)
☐ Disabled
☐ Current Medicare Beneficiary
☐ *Covered by a group health insurance plan *(if required by your plan)*

☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____

Last Name: _____ First Name: _____ (MI): ____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:
☐ End Stage Renal Disease (ESRD)
☐ Disabled
☐ Current Medicare Beneficiary
☐ *Covered by a group health insurance plan *(if required by your plan)*

(Over Please)

Effective for plan years that begin on or after December 1, 2019, reimbursement of expenses from your HRA can only be for you, your spouse and/or your eligible dependents who are covered under a group health insurance planas outlined in your Plan Highlights.

☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____

Last Name: _____ First Name: _____ (MI): ____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:

☐ End Stage Renal Disease (ESRD)

☐ Disabled

☐ Current Medicare Beneficiary

☐ *Covered by a group health insurance plan *(if required by your plan)*

☐ Add ☐ Remove

Relationship to Participant: ☐ Spouse ☐ Domestic Partner ☐ Child SSN: _____

Last Name: _____ First Name: _____ (MI): ____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Medicare Health Claim Number (HICN): _____ *(if applicable)* Effective Date of HRA Coverage: _____ / _____ / _____

Please check all that apply:

☐ End Stage Renal Disease (ESRD)

☐ Disabled

☐ Current Medicare Beneficiary

☐ *Covered by a group health insurance plan *(if required by your plan)*

C. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual* and must not be reimbursed from any other source. I also understand that if I or my spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a general Health Reimbursement Account (HRA). If the HRA is an HSA-compatible plan (e.g. limited purpose, post-deductible), HSA contributions can be made.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law. I verify that the information detailed above is true and accurate. I understand that certain information being requested is necessary to comply with the mandatory Section 111 reporting and will be sent to The Centers for Medicare & Medicaid Services (CMS).

If an FBA Benefits Card is associated with my HRA:

- I authorize the issuance of an FBA Benefits Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my FBA Benefits Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-taxbasis. I also authorize expenses for replacement cards and paper follow up requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the FBA Benefits Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such follow up documentation to FBA upon request.

Signature: _____ Date: _____ / _____ / _____

D. EMPLOYER SECTION *(to be completed by the employer)*

- **Effective date of enrollment/change:** _____ /_____ /_____
- **Account Type:** ☐ Health Reimbursement Account
  ☐ Limited Health Reimbursement Account *(Reimburses dental, vision and/or post-deductible expenses as allowed by the plan. Participants cannot receive contributions to this account ifcontributions are being made to a Health Reimbursement Account.)*
- ***Please select only one option:***
  ☐ New Enrollment: funding amount _____ ☐ per plan year ☐ Other_____
  ☐ Termination ☐ Resignation ☐ Retirement ☐ Change in hours ☐ Other_____
- **Health Insurance Coverage Code: ___ ___ ___ ___ ___ ___** ***This information is required for FBA Benefits Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NO MED.***

Please select funding:

☐ Single

☐ Two-Person

☐ Family

Effective for plan years that begin on or after December 1, 2019, reimbursement of expenses from your HRA can only be for you, your spouse and/or your eligible dependents who are covered under a group health insurance planas outlined in your Plan Highlights.