Health Reimbursement Arrangement Enrollment Form

(All Information is Required)

Employer: _____

Employee Name:_____ Date of Hire:_____

Address:_____

Social Security Number:_____ Date of Birth:_____

Day Telephone:_____ Email Address:_____

Single or Family:	Election Amount:

Dependents:

Name:_____ Name:_____

DOB:_____ SSN:_____ DOB:_____ SSN:_____

Name:_____ Name:_____

DOB:_____SSN:_____ DOB:_____ SSN:_____

Participant Authorization:

I request to participate in the benefits indicated above. I understand that my elections indicated are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan. If I have waived participation, I understand that I may not join the Plan until the start of the next plan year.

Employee Signature:_____ Date:_____

RSS Agency
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