



**Health Reimbursement Arrangement (HRA)
Employee Election Form**

Employee Name: _____

Employee Social Security Number: _____ Phone # _____

Address: _____

City: _____ State/Zip: _____

____ I am a full time employee, and I understand my employer is sponsoring a Health Reimbursement Arrangement (HRA) on my behalf. I understand this is an employer funded account, and I have been explained the details of said account, and I understand how to request reimbursement under this plan and I would like to participate in this account.

Signature

Date

____ I **do not** wish to participate in my employer funded HRA Plan.

Signature

Date