HRA Employee Eligibility Form

Employer Name:			Division:
Employee Name:			☐ Male ☐ Female
Date of Birth:	Social Security #:		
Street:	City:	State:	Zip:
Date of Hire:	HRA Eligibility Date:	Termination/Benefit End Date:	

Benefit Information

HRA Benefit Amount	☐ **I decline HRA benefit coverage.**	
Type of Coverage:	☐ Employee Only	☐ Employee + Child(ren)
	☐ Family	☐ Employee + Spouse

Dependents Covered by HRA

First Name	Last Name	Social Security #	Date of Birth	Relationship to Employee

Medicare Eligibility

Is the employee or any dependent enrolled in Medicare? ☐ Yes ☐ No

Medicare Participant Name	Medicare Health Insurance Claim Number (HICN)	Effective Date Eligibility/Entitlement Part A	Effective Date Eligibility/Entitlement Part B	Effective Date Eligibility/Entitlement Part D

Employee Signature _____ **Date** _____

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