PacificSource ADMINISTRATORS

Health Reimbursement Arrangement (HRA) Enrollment and Change Form

Please print responses. * = required field ☐ Enrollment ☐ Change

1. Employment

Employer* _____ Division/Class _____

Hire Date (required for mid-yr enrollment) _____ HRA Effective Date* _____ First Contribution Date _____

PSA Member ID (if applicable) _____ Employee ID _____ No. of Hrs. Worked per Wk _____

Qualifying Event (if applicable) _____ Event Date _____

2. Employee (indicate changes using check boxes; include only **new** information)

Employee Last Name* _____ ☐ change First Name,* MI _____

Birth Date* _____ Social Security No. _____ ☐ change

Mailing Address* _____ ☐ change

City* _____ State* _____ ZIP* _____

Primary Phone _____ ☐ change Secondary Phone _____ ☐ change

Email (if provided, notifications may be sent via email) _____ ☐ change

Beneficiary Name and Relationship _____ ☐ change

3. Dependents

Dependent information is only required for enrollment in certain plans. Please see your plan administrator to determine whether or not this information is needed for your plan. Use check boxes to indicate if you are adding or removing dependents.

Dependent Demographics		Last Name*	First Name*	MI	Social Security No.*	Birth Date*
Spouse	☐ add ☐ remove					
Child	☐ add ☐ remove					
Child	☐ add ☐ remove					
Child	☐ add ☐ remove					
Child	☐ add ☐ remove					

☐ Check here if you or your dependents are enrolled (or plan to enroll) in a health savings account
☐ Check here if you are not eligible (or won't be eligible) in your employer's group sponsored medical plan

Continued on reverse >

4. Contribution**

Annual HRA Contribution HRA 1 $_____ Plan Description _____

Annual HRA Contribution HRA 2 $_____ Plan Description _____

Annual HRA Contribution HRA 3 $_____ Plan Description _____

***If the HRA contribution is based on the number of family members, dependent information must be listed above in Section 3.*

5. Optional Features

Optional features may not be available for all plans. See your plan summary or ask your employer for additional information. If available, you may elect the Benny™ Debit Card. Additional Benny™ Card restrictions may apply. HRA claims may still be submitted via fax, mail, or electronically through our MyFlex website. **Select one from the following choices:**

Benny Debit Card	A Benny™ Prepaid Benefits Card deducts directly from your HRA at the point of sale. Itemized receipts are required for all transactions that are not auto-substantiated at the point of sale. There is no additional cost for acquiring your initial Benny Prepaid Benefits Cards. Upon expiration (5 years) a new set will be automatically mailed for no additional fee. *Select if you would like to enroll and/or remain enrolled, or disenroll.*	☐ Enroll and/ or Remain Enrolled ☐ Disenroll
Replacement Benny Debit Card	A set of two replacement/additional Benny™ Prepaid Benefits Cards are available for a fee of $10. This fee is deducted from your HRA account. Please indicate if your cards have been lost or stolen (and you would like to replace your cards with new numbers). *Or* indicate if you would like to order additional cards with the same card number.	☐ Lost/Stolen ☐ Additional
EasyPay	EasyPay is the automatic reimbursement of eligible claims processed by PacificSource Health Plans. Employees must be enrolled in their employer's PacificSource plan to be eligible for EasyPay. Employees or their family members with secondary coverage are not eligible for EasyPay. In order to be enrolled, an EasyPay enrollment form must be signed and returned. The EasyPay form is available at PSA.PacificSource.com/Forms_Flex.aspx.	

6. Participant Authorization or Waiver

☐ **Participant Authorization**
I hereby certify the information provided on this form is correct and true to the best of my knowledge. I understand that some of the above information may only be changed due to a qualifying event and during the open enrollment period. I further understand that any amounts remaining in my account at the end of the plan year will be forfeited. Upon termination, unused funds will be forfeited in accordance with Section 213 regulations.

☐ **Participant Waiver**
I do not wish to participate in the plan, and waive enrollment for the Health Reimbursement Arrangement. I understand that by refusing to participate, I will be unable to enroll this plan year unless my employer allows mid-year changes and I experience a qualifying event, in accordance to the IRS Code section 213, and submit the change within 30 days of the qualifying event.

Employee Signature* _____ Date _____

Employer Authorization* _____ Date _____

Employee: *Please return the original to your employer and retain a copy for your records.*

Employer: *Please audit the form, confirm the change is consistent with the event, and confirm your plan allows changes as indicated. Once approved, retain a copy for your records, and forward a copy to PacificSource Administrators for processing.*

PacificSource Administrators P.O. Box 70168, Springfield, OR 97475-0110; (541) 485-7488, (800) 422-7038; fax (541) 225-3648, (800) 575-1109; PacificSource.com/PSA