HRA ENROLLMENT FORM

☐ Support Staff
☐ Faculty
☐ Administrative
☐ Low Plan Option

Enroll ARORx/Maxor Automatic ☒

email: enrollment@44N.com

*Please **print CLEARLY** and complete **ALL** fields*

SUBSCRIBER INFORMATION

EMPLOYER: Lake Superior State University	PLAN YEAR FROM:	TO:	
SSN:	DATE OF HIRE:	BENEFIT EFF DATE:	
FULL NAME:	BIRTH DATE:	☐ M ☐ F	☐ Married ☐ Single
MAILING ADDRESS:	DAYTIME PHONE:		
CITY: ST: ZIP:	EMAIL***:		

	DEPENDENT NAME (FIRST MI LAST)	SSN	BIRTH DATE	RELATIONSHIP	SEX
☐ Add ☐ Delete	(1)			☐ Spouse ☐ Child	☐ M ☐ F
☐ Add ☐ Delete	(2)			☐ Spouse ☐ Child	☐ M ☐ F
☐ Add ☐ Delete	(3)			☐ Spouse ☐ Child	☐ M ☐ F
☐ Add ☐ Delete	(4)			☐ Spouse ☐ Child	☐ M ☐ F
☐ Add ☐ Delete	(5)			☐ Spouse ☐ Child	☐ M ☐ F
☐ Add ☐ Delete	(6)			☐ Spouse ☐ Child	☐ M ☐ F
☐ Add ☐ Delete	(7)			☐ Spouse ☐ Child	☐ M ☐ F

COORDINATION OF BENEFITS INFORMATION – PLEASE COMPLETE IF YOU HAVE ANY OTHER COVERAGE

OTHER COVERAGE ☐ YES ☐ NO If Yes, Complete Below		NAME OF SPOUSE'S EMPLOYER:	
NAME OF SPOUSE'S GROUP INSURANCE(S) OR HMO:			TYPE OF COVERAGE
MEDICAL COVERAGE	☐ YES ☐ NO IF YES, GROUP #:		☐ SINGLE ☐ FAMILY
DENTAL COVERAGE	☐ YES ☐ NO IF YES, GROUP #:		☐ SINGLE ☐ FAMILY
VISION COVERAGE	☐ YES ☐ NO IF YES, GROUP #:		☐ SINGLE ☐ FAMILY
PRESCRIPTION COVERAGE	☐ YES ☐ NO IF YES, GROUP #:		☐ SINGLE ☐ FAMILY
MEDICARE ENROLLEES *	☐ YOURSELF	MEDICARE #:	☐ Age ☐ Disability ☐ ESRD
MEDICARE ENROLLEES *	☐ SPOUSE	MEDICARE #:	☐ Age ☐ Disability ☐ ESRD
MEDICARE / MEDICAID / OTHER *	☐ ELIGIBLE DEPENDENT	DEPENDENT NAME(S):	ID # ☐ ESRD
MEDICARE / MEDICAID / OTHER *	☐ ELIGIBLE DEPENDENT	DEPENDENT NAME(S):	ID # ☐ ESRD

** If you, your spouse or any dependent(s) listed are enrolled in Medicare, please attach a copy of your Medicare card(s)*

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

☒ YES, I ELECT TO PARTICIPATE IN THE HRA PLAN	PAPERLESS EOBS *** ☐ **YES** ☐ **NO**

CERTIFICATION

By signing this form I certify that these are my benefit elections and that:

1. I understand that having agreed to enroll, that I will have no right to participate in the benefit plan and that this benefit will not be available to me, until I have completed, signed and returned the enrollment form and my enrollment is accepted. I understand that coverage applies only to expenses incurred during my participation in the plan
2. I understand, that as of the first day of the plan year, that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in my family status as defined in the Plan Documents which includes a change in my employment or spouse's employment status
3. My health reimbursement account election is for eligible medical expenses for myself, my spouse and my tax dependents
4. Reimbursement claims must be accompanied by IRS approved documentation of the out-of-pocket expense that includes date, type, recipient and provider of service along with the amount charged and balance due
5. I certify that I will not seek reimbursement for expenses reimbursed by the HRA Plan under any major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit
6. I understand that coverage applies only to expenses incurred during my participation in the plan
7. *** I understand that if I elect to have paperless EOBs, I must supply an email address and I must log onto the internet to retrieve EOBs for any claim processed, including but not limited to claims paid, claims adjusted and claims denied.

Employee Signature: _____ **Date:** _____