Health Reimbursement Arrangement (HRA) Participant Enrollment Form

DataPath Administrative Services

Employer Name _____

Applicant Last Name _____ First Name _____ Middle Initial ____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Address _____ City _____ State _____ Zip _____

Home or Cell Phone _____ Work Phone _____ Email _____

HRA Benefit Name _____ **HRA Effective Date** (mm/dd/yyyy) _____

Coverage Tier: ☐ Self Only ☐ Self & Spouse ☐ Self & Children ☐ Family

Medicare Secondary Payor (MSP) Reporting Information

Are you a Medicare beneficiary: ☐ Yes ☐ No If Yes, provide Medicare HICN here: _____

Payment Information

Reimbursement will be made by Electronic Funds Transfer (Direct Deposit) into your checking or savings account. Please provide bank account information below or attach a voided check.

☐ I choose Direct Deposit for my payment method.

Routing Transit Number
(All nine boxes must be filled)

Account Number
(Include hyphens, but not spaces and special symbols)

– ATTACH VOIDED CHECK HERE –

I hereby certify information provided herein to be correct and true and choose to participate.

Signature _____ **Date** (mm/dd/yyyy) _____

please proceed to page 2

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** **IMPORTANT:** **If your spouse or any of your dependents are covered by the health insurance plan listed on the reverse side please complete the form below for each person (besides yourself) who is covered by the HRA plan.**

Dependent #1

Name _____ Gender ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #2

Name _____ Gender ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #3

Name _____ Gender ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #4

Name _____ Gender ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

If you have more than four dependents covered by this health insurance plan, please provide the above information about each person on a separate sheet of paper and attach to this form.

DataPath Administrative Services, Inc. | 1601 Westpark Drive, Ste 9 | Little Rock, AR 72204
Toll-Free 866-207-3028 | Fax 855-504-3457 | vtsupport@datapathadmin.com