HRA Enrollment Form _____

Company Name

Employee Name _____

Social Security Number_____ / _____ / _____ Effective Date ___ / ___ / ___

Date of Birth ___ / ___ / ___ Sex: Female ___ Male ___ Date of Hire ___ / ___ / ___

Home Telephone (_____) _____ - _____ Work Telephone (_____) _____ - _____

Street Address/PO Box _____

City _____ State _____ Zip _____

Full-Time _____ Part-Time _____ Seasonal (Less than 6 months per year) _____

Spouse's Employer _____Are you covered under spouse's plan? Y ___ N ___

List of Dependents

Code	First Name	Last Name	Date of Birth	Social Security #
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____
			__/__/__	_____ / _____ / _____

Code: "S" = Spouse "C" = Child "A" = Adult Dependent

I authorize FlexSource to release my Health Reimbursement Account (HRA) claim information to the other adult dependents in my family (signatures below) in the event that there is a telephone inquiry made to FlexSource by that dependent.

Employee Signature _____ Date ____ / ____ / ____
Spouse or Adult Dependent Signature _____ Date ____ / ____ / ____

FlexSource, LLC
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